DEPARTMENT OF HEALTH & HUMAN SERVICES

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

July 8, 2019

Melissa Weaver
RN, LNHA
Hickory Manor
209 Hickory Street
Licking, MO 65542

Byron Lamprecht
Supervisor - Cost Report Appeals
WPS Government Health Administrators (J-5)
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Dismissal for Untimely Filing
Hickory Manor
Provider Number: 26-5632
Appealed Period: FFY 2018
PRRB Case Number: 19-0369

Dear Ms. Weaver and Mr. Lamprecht:

Pursuant to 42 C.F.R. § 405.1868, the Provider Reimbursement Review Board ("Board") has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations. The Board's powers include the authority to take appropriate actions in response to the failure of a party to comply with Board rules and orders. Specifically, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. In a Critical Due Dates Notice dated November 20, 2018, the Board advised that the preliminary position paper or a proposed joint scheduling order must be submitted by June 26, 2019. Since neither a preliminary position paper nor a proposed joint scheduling order was submitted to the Board by the due date, the Board hereby dismisses this case.

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

FOR THE BOARD:

Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207

Mr. Michael G. Newell
President
Southwest Consulting Associates
2805 Dallas Parkway, Suite 620
Plano, TX 75093-8724

Mr. Bruce Snyder
JL Provider Audit Manager
Novitas Solutions, Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Southwest Consulting Summit Health 2012 SSI Fraction Part C Days CIRP Group
PRRB Case No.: 15-0025GC

Dear Mr. Newell and Mr. Snyder:

The Provider Reimbursement Review Board ("Board") is in receipt of the letter and Form E-Request to Directly Add Provider to Group dated June 18, 2019 requesting that Waynesboro Hospital, Provider No. 39-0138 be added to the above-captioned CIRP (Common Issue Related Party) group.

Upon review, it is noted that you had previously requested the withdrawal of case number 15-0025GC in December 2015. In response, the Board closed case number 15-0025GC by letter dated December 18, 2015.

The Board hereby **denies** the request to directly add Waynesboro Hospital, Provider No. 39-0138 to case number 15-0025GC. The subject CIRP group case is in a closed status pursuant to your earlier request for withdrawal and a provider cannot be added to a case that is closed and no longer actively pending before the Board. Please adjust your records to reflect that case number 15-0025GC was withdrawn and closed by the Board on December 18, 2015.

If you wish to pursue an appeal for this provider, you must establish a new group appeal and refile the direct add request or file an individual appeal request for this provider within 180 days from receipt of the final determination under appeal.

Board Members Participating

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

FOR THE BOARD:

7/8/2019

X Charlotte F. Benson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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William Brooks
Accountant
Tangu, Inc.
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Cecile Huggins
Appeals Manager, Provider Cost Report Appeals
Palmetto GBA
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

Re: Case Dismissal
Tangu, Inc. (11-4624), FYE 12/31/2016
Case No. 19-1859

Dear Mr. Brooks and Ms. Huggins:

On April 4, 2019, the Provider Reimbursement Review Board ("Board") received an appeal request for Tangu, Inc., which was assigned case number 19-1859. The background of the case and the decision of the Board are set forth below.

Background

The filed appeal request was a hard copy of an email dated March 21, 2019 from Mr. Brooks sent to the Appeal Support Contractor (Federal Specialized Services) and the Medicare Administrative Contractor (Palmetto GBA (J-J)). Also enclosed in the envelope was a cd that was labeled "Tangu, Inc. 11-4624 Backup," but the disc had no recognizable files.[1]

Decision of the Board

The Board finds that the Provider's appeal request is jurisdictionally deficient as the Provider failed to submit the final determination under appeal and supporting documentation for the issue in dispute.

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835(a), a provider has a right to a hearing on a final contractor or Secretary determination for the provider's cost reporting period if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for a hearing is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

[1] The file format on the disc was blank and the used space was 0 bytes.

42 C.F.R. § 405.1835(b) addresses the required contents of a request for a Board hearing on a final contractor determination. Specifically, the regulations require that an appeal request include:

> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of the same section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (2) A separate explanation for each specific item under appeal and a description of how the provider is dissatisfied with the specific aspects of the final determination.
>
> (3) A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements.

See also Board Rules 6 and 7 that address "Filing an Individual Appeal" and "Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction."

If a Provider's appeal request does not meet the requirements above, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. 42 C.F.R. § 405.1868.

Because the Provider failed to submit the final determination under appeal or to provide issue-specific support for the bad debt item under appeal, the Provider did not meet the regulatory requirements or Board instructions for filing a complete PRRB appeal. Therefore, the Board finds that the appeal request is jurisdictionally deficient and hereby dismisses Case No. 19-1859.

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:

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

For the Board:

7/8/2019

X Charlotte Benson

Charlotte Benson
Board Member
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Wade Snyder
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Bruce Snyder
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Pittsburgh, PA 15219

Justin Lattimore
Novitas Solutions, Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Jurisdictional Determination

PRRB Case No. 14-3677 – SSM Rehabilitation Hospital (26-3031) FYE 06/30/2011
PRRB Case No. 14-3692 – SSM Rehabilitation Hospital (26-3031) FYE 06/30/2012
PRRB Case No. 14-3671 – Penn State Hershey Rehabilitation (39-3053) FYE 05/31/2012
PRRB Case No. 14-3693 – West Gables Rehabilitation Hospital (10-3036) FYE 12/31/2011

Dear Mr. Snyder, Mr. Lamprecht, Mr. Snyder, and Mr. Lattimore:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2011 through 2012. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018.[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

The Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2011 through 2012. In its RFH, the Providers' list a single issue for appeal — the removal of Medicare Advantage days from the SSI fraction denominator of the Low-Income Patient ("LIP") for inpatient rehabilitation distinct-part units ("IRFs").

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Medicare Advantage Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] The Court of Appeals 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.[5]

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[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[6] As this is the only issue under appeal in these cases, they are hereby closed.

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

Board Members Participating:

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

For the Board:

7/8/2019

X Charlotte F. Benson

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

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

[6] 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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Electronic Delivery

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

RE: **EJR Determination**

14-0567GC	QRS Novant 2007 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3075GC	QRS Progressive Acute Care 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3129GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-3279GC	QRS Health First 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3280GC	QRS Health First 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
15-3171GC	QRS BSWH 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-3172GC	QRS BSWH 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
16-1239GC	QRS Asante 2013 DSH SSI Fraction Medicare Managed Care Part C Days Group
16-1240GC	QRS Asante 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran:

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

Issue in Dispute:

The issue in these appeals is:

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

[1] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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[13] 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].[14]

[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[15]

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

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

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

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."[19] In response to a comment regarding this change, the Secretary explained that:

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

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[15] *Id.*
[16] 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.
[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[19] 69 Fed. Reg. at 49099.

> *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.[20]

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.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[22] 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."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] 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.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] 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*.[27] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 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).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.

Medicare fractions published for FY 2012.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007, 2011-2013.

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

[28] *Id.* at 943-945.
[29] Providers' EJR Request at 1.
[30] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[31]

On August 21, 2008, new regulations governing the Board were effective.[32] 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*").[33] 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.[34]

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.

Improper *Inclusion of Previously Dismissed Provider on Schedule of Provid*ers

The Board notes that the Schedules of Providers submitted in case numbers 15-3171GC and 15-3172GC on June 17, 2019, improperly includes #6 BSW MC-Carrollton f/k/a Baylor MC-Carrollton (provider number 45-0730). The Board previously concluded that it lacked jurisdiction over the appeal of BSW MC-Carrollton in case number 16-0221 because the appeal was not timely filed. The case was dismissed on July 20, 2016. Notwithstanding the Provider Representative's *improper* attempt to in include the Provider on the Schedule of Providers, this Provider is not currently a participant in in case numbers 15-3171GC and 15-3172GC. As a result, #6 BSW MC-Carrollton's request for EJR is hereby denied.

Jurisdiction and Request for EJR for the Remaining Providers

The Board has determined that the remaining participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling 1727-R. In addition,

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

the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] Although case numbers 14-0567GC, 15-3279GC, 15-3280GC, 16-1239GC and 16-1240GC were established as group appeals, they only have a single participant[36] and the Board is electing to treat the cases as individual appeals. In those cases, the $10,000 amount in controversy for an individual appeal has been met.[37] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007, and 2011-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [40]

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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[35] *See* 42 C.F.R. § 405.1837.
[36] In case number 10-0924GC, the appeal contains a single participant that appealed two different fiscal years. Case number 13-3253GC contains a single participant.
[37] *See* 42 C.F.R. § 405.1835(a).
[38] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[39] *See* 42 U.S.C. § 1395oo(f)(1).
[40] One of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

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

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

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

Enclosures: Schedules of Providers

cc: Geoff Pike, First Coast Service Options
Byron Lamprecht, WPS
Justin Lattimore, Novitas
John Bloom, Noridian
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: **Expedited Judicial Review Determination**

14-3812GC Southwest Consulting CHE 2011 DSH SSI Fraction Part C Days Group
14-3828GC CHE 2011 DSH Medicaid Fraction Part C Days Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 18, 2019 request for expedited judicial review (EJR) (received June 19, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> Whether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI[1] fraction and excluded from the Medicaid fraction numerator or vise-versa.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] Providers' EJR Request at 3.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

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[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] (Emphasis added.)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [18]

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

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

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to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[20] 69 Fed. Reg. at 49099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] 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.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] 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*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.

Providers' Request for EJR

The issue under appeal in this case involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[30]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[31] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In this case, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-

[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[32] 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.[33]

On August 21, 2008, new regulations governing the Board were effective.[34] 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).*[35] 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.[36]

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.

Additionally if a participant files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[37] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[32] 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.).
[33] *Bethesda at 1258-59.*
[34] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016)
[36] *Banner* at 142.
[37] See 42 C.F.R. § 405.1889(b)(1) (2008).

Jurisdictional Determination: Appeals of Revised NPRs
Case Number 14-3812GC: #10 Mercy Suburban Hospital (provider number 39-0116)

#10 Mercy Suburban Hospital appealed its revised NPR that did not adjust the Part C issue as required for Board jurisdiction, rather it was an appeal of an SSI realignment of the SSI% to the providers cost reporting year, as evidenced by the December 5, 2017 Notice of Reopening.[38] The Notice of Reopening stated that the Medicare Contractor was reopening the Provider's cost report "to review your request to recalculate the hospital's Acute SSI percentage based on the hospital's fiscal year 12/31/2011."

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

CMS does not utilize a new or different data match process when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.

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

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

[38] Provider's December 19, 2018 Hearing Request.

> Since the revised NPR for Mercy Suburban Hospital did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that is lacks jurisdiction over the revised NPR and hereby dismisses the appeal of the revised NPR for #10 Mercy Suburban Hospital. Because jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Provider's request for EJR involving the revised NPR from case number 14-3812GC.[39] The Provider's original NPR appeal will remain pending in the case.

Jurisdiction and EJR for the Remaining Providers

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[40] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction over the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the cost reporting period 2011, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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[39] *See* 42 C.F.R. § 405.1842(a).
[40] *See* 42 C.F.R. § 405.1837.

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

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

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

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

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

Enclosure: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services
Office of Hearings
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President
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2805 Dallas Parkway, Suite 620
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Mr. Bruce Snyder
JL Provider Audit Manager
Novitas Solutions, Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Southwest Consulting Summit Health 2012 SSI Fraction Part C Days CIRP Group
PRRB Case No.: 15-0025GC

Dear Mr. Newell and Mr. Snyder:

The Provider Reimbursement Review Board ("Board") is in receipt of a Request for Expedited Judicial Review (EJR) for the subject group appeal dated July 2, 2019. Upon review, it is noted that you had previously requested the withdrawal of case number 15-0025GC in December 2015. In response, the Board closed case number 15-0025GC by letter dated December 18, 2015.

The Board hereby **denies** the request for EJR in case number 15-0025GC. The subject CIRP group case is in a closed status and is no longer actively pending before the Board. Please adjust your records to reflect that case number 15-0025GC was withdrawn and therefore closed by the Board on December 18, 2015.

Board Members Participating

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

RE: **EJR Determination**

15-0731GC QRS BHCS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-0732GC QRS BHCS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran:

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

Issue in Dispute:

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Providers' EJR request at 1.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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[13] 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].[14]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[15]

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[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*

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

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

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

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."[19] In response to a comment regarding this change, the Secretary explained that:

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

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[16] 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.

[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[19] 69 Fed. Reg. at 49099.

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

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.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[22] 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."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] 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.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] 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*.[27] The D.C. Circuit further found in *Allina II* that the

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 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).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.

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

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

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

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

[28] *Id.* at 943-945.
[29] Providers' EJR Request at 1.
[30] 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.[31]

On August 21, 2008, new regulations governing the Board were effective.[32] 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*").[33] 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.[34]

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the appeals were timely filed and participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[35] 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.

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

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

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[36] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte Benson

Charlotte Benson, CPA
Board Member
Signed by: PIV

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas Solutions
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Arcadia, CA 91006

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

15-2930GC QRS St. Luke's Post 10/1/2004, 2005, 2007 Medicare Managed Care Part C Days Grp.

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 8, 2019[1] request for expedited judicial review ("EJR") for the appeal referenced above.[2] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[3]

[1] On May 22, 2019, the Board sent a Request for Information to the Providers' representative, Quality Reimbursement Services, Inc. ("QRS") and to the Medicare Contractor. The Board asked *both* parties for additional information with respect to Provider in the group that has a fiscal year that *begins* in federal fiscal year ("FFY") 2004 ***and*** *ends* in FFY 2005. In this letter, the Board gave both parties 30 days to respond, and indicated that the request for additional information stayed the 30-day period for responding to the EJR request. QRS submitted its response on June 14, 2019. The Medicare Contractor submitted its response on June 18, 2019. The Group name and Schedule of Providers already reflect that for the Provider appealing the 2004 cost reporting period, the period under appeal is from 10-1/2004 – 12/31/2004.

[2] The EJR request included 8 other groups: 14-0959GC; 14-0960GC; 15-2621GC; 15-2622GC; 15-1371GC; 15-1372GC; 16-1008GC; and 16-1102GC. The Board issued a decision granting EJR for these appeals on May 31, 2019

[3] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

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[15] 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

[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [19]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[20]

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."[21] In response to a comment regarding this change, the Secretary explained that:

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[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*
[18] 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.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[22]

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.[23] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[24] 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."[25]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[26] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] 72 Fed. Reg. at 47411.
[25] 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).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] 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*.[29] 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.[30] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers explain that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I]*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 Rule."[31] Accordingly, the Providers contend that the Board should grant their request for EJR.

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

Decision of the Board

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

Jurisdiction for the Group Participants

The participants that comprise the group appeals within this EJR request have filed appeals involving the 2004, 2005, and 2007 cost reporting periods. Based on the Providers

[27] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] EJR Request at 1.

representative's June 14, 2019 response to the Board's Request for Information, as well as the Board's previous bifurcation of Case No. 09-0532GC to establish this group, the period at issue for these appeals is ***only*** for discharges on or after 10/1/2004.

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

A. Jurisdictional Determination On Certain Specific Individual Participants

At the outset, the Board notes that a Board finding of jurisdiction is a prerequisite to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision,"[34] including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[35]

1. Participants 1 and 2 – St. Luke's Hospital, Provider No. 26-0138, FYEs 10/1/2004 – 12/31/2004 and 12/31/2005

   The Board finds that it does not have jurisdiction over Participants 1 and 2, St. Luke's Hospital for 12/31/2004 and 12/31/2005, because the Provider did not establish that it timely added the Part C days issue to its individual appeals prior to requesting to transfer the issue to Case No. 09-0532GC (which was subsequently bifurcated to create this group appeal).

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[32] 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.).

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

[34] 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which included a decision on both jurisdiction and the EJR request).

[35] 42 C.F.R. 405.1837(e)(2) states: "*The Board may make jurisdictional findings* under § 405.1840 ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings."

Case No. 15-2930GC was established on July 10, 2015 from a bifurcation of Case No. 09-0532GC. The Board issued a decision in light of *Northeast Hosp. Corp. v. Sebelius* which resulted in Medicare Contractors including patient days attributable to patients who were enrolled in a Medicare Part C plan and also eligible for Medicaid for discharges occurring on or after January 1, 1999 through September 30, 2004 in the Medicaid fraction. Therefore, on July 10, 2015, the Board created a separate CIRP group for the period from 10/1/2004 and after, and assigned that group Case No. 15-2930GC (which is the subject of this EJR request). The Board transferred St. Luke's for the period 10/1/2004 – 12/31/2004 and FYE 12/31/2005, and St. Luke's East – Lee's Summit for 12/31/2007 to this group. These are the current Providers and cost reporting periods that make up Case No. 15-2930GC.

St. Luke's was issued an original NPR for FYE 12/31/2004 on September 21, 2006. The Provider filed its initial appeal request with the Board on March 19, 2007, which did **not** include the Part C Days issue. St. Luke's was issued an original NPR for FYE 12/31/2005 on February 23, 2006. The Provider filed its initial appeal request with the Board on August 21, 2007, which did **not** include the Part C Days issue.

The Provider purportedly requested to add the Part C days issue to its individual appeals for FYE 2004 and 2005 on October 17, 2008, however "QRS was unable to locate the delivery notification of the Model Form C. The date provided for the add issue request is the date the Model Form C was sent to the Board." PRRB Rule 21.3.2 states that the following must be included with the Schedule of Providers and jurisdictional documents:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

In 2008, the Board's regulations were updated following the appropriate notice and comment period.[36] These regulations imposed limits on the ability of providers to add issues to pending appeals by requiring that any such claims be added by October 20, 2008.[37] St. Luke's had appeals pending at this time for its 12/31/2004 and 12/31/2005 FYEs; therefore it had until October 20, 2008 to add any issues to its pending individual appeals. The Schedule of Providers indicates that the Model Form C requests to add issues were submitted on October 17, 2008, however there is nothing in the record to determine when the Board received those requests. Therefore, the Board is not able to determine whether the Provider timely added the Part C days issue to its individual

[36] 73 Fed. Reg. 30190, 30265-30267 (May 23, 2008).
[37] *See* 42 C.F.R. § 405.1835(c).

appeals prior to requesting to transfer the issue to the group (that was eventually bifurcated to establish this group that is the subject of the EJR request).

The Board denies jurisdiction over St. Luke's Hospital's FYE 12/31/2004 and 12/31/2005 appeals and dismisses the Provider from Case No. 15-2930GC.

B. Jurisdictional Determination for Remaining Participants

The Board has determined that the remaining participant's appeals involved with the instant EJR Request are governed by the decision in *Bethesda* and the Provider timely filed its appeal. As only one participant remains in the appeal, the Board is treating it as an individual appeal.[38] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the remaining participant.

Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request for the remaining participant involves the cost reporting period 2007. Thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[39]

Board's Decision Regarding the EJR Request

The Board finds that:

[38] The Schedule of Providers indicates that the remaining participant's amount in controversy is $7,000. However, because this may not be the final amount in controversy, the group initially met the amount in controversy, and this group was established as part of a bifurcation, the Board finds that the amount in controversy requirement is satisfied. *See* 42 C.F.R. § 405.1837

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

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

2) Based upon the participant's assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining 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 Case No. 15-2930GC.

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *Request for Information*

17-0568GC QRS WVUHS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
17-0571GC QRS WVUHS 2013 DSH SSI Fraction Medicare Managed Care Part C Days Group

Dear Mr. Ravindran and Ms. Polson:

As explained below, the Board is writing to request additional information from Quality Reimbursement Services, the group representative, regarding the above-referenced appeals. These groups consists of Providers, each who have a fiscal year that *begins* in federal fiscal year ("FFY") 2013 ***and*** *ends* in FFY 2014. This request for additional information affects the 30-day period for responding to the EJR request[1] and it also may impact the Board's ruling on that EJR request.

By way of background, the Secretary announced a new policy in the final rule for the FFY 2005 inpatient prospective payment system ("IPPS") published on August 11, 2004 specifying that Medicare Part C days would be counted in the SSI fraction (also referred to as the "Medicare fraction") for discharges on or after October 1, 2004 (the "FFY 2005 Part C Days SSI Policy"). The following issue in these appeals dispute the application of this policy:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[2]

Although the FFY 2005 Part C Days SSI Policy 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 codifying this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B)

[1] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).
[2] Providers' EJR request at 1.

and (b)(2)(iii)(B).[3] Thus, as a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004.[4]

Multiple providers subjected the FFY 2005 Part C Days SSI Policy as codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) to much litigation by challenging these regulatory provisions under the Administrative Procedure Act. On November 15, 2012, the U.S. District Court for the District of Columbia issued its decision in *Allina Healthcare Services v. Sebelius* finding in favor of the providers.[5] Following this decision, "in an abundance of caution," CMS published a proposed rule on May 10, 2013 to readopt the regulations codifying the FFY 2005 Part C Days Policy.[6] In the final rule published on August 19, 2013, CMS readopted its then-existing regulations at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) without "any change to the regulation text because the current text reflects the policy."[7] This readoption was effective for discharges occurring on or after October 1, 2013 and will be referred to as the "FFY 2014 Readopted Part C Days Policy."[8]

Based on the group appeal requests for case numbers 17-0568GC and 17-0571GC, it is the Board's understanding that the Providers are requesting that their Part C days not be counted in the SSI fraction as required under 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) but rather that they be counted in the Medicaid fraction. However, the fiscal years at issue for two Providers in case numbers 17-0568GC and 17-0571GC begin in FFY 2013 and end in FFY 2014 and is necessarily affected by both the FFY 2005 Part C Days SSI Policy and the FFY 2014 Readopted Part C Days Policy.

Accordingly, the Board requests the group representative to confirm whether *the group appeals for* case numbers 17-0568GC and 17-0571GC are challenging ***only*** the FFY 2005 Part C Days SSI Policy (as laid out in the EJR request) and, as a result, are ***only*** seeking relief with respect to those Part C Days occurring ***prior to October 1, 2013*** (*i.e.*, the group appeal itself is only requesting that any Part C Day occurring prior to October 1, 2013 be moved from the SSI fraction to the Medicaid fraction for the fiscal years at issue). If this is not true, the Board may

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[3] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007). In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). *Id.* at 47411.

[4] 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." 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).

[5] 904 F. Supp. 2d 75 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

[6] 78 Fed. Reg. 27846, 27578 (May 10, 2013).

[7] 78 Fed. Reg. 50496, 50618, 50620 (Aug. 19, 2013).

[8] *Id.* at 50496 (stating "These changes will be applicable to discharges occurring on or after October 1, 2013, unless otherwise specified in this final rule").

seek additional information from the group representative and may also require bifurcation as appropriate and relevant.

The Board requests that the group representative respond to the Board's request for information ***within 15 days of the issuance of this letter.*** Again, this request for additional information stays the 30-day period for responding to the EJR request for case numbers 17-0568GC and 17-0571GC and it also may impact the Board's ruling on that EJR request.

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

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

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RE: *Expedited Judicial Review Determination*

19-1909G	Blumberg Ribner CY 2013 Medicare HMO Part C Days-Medicare Fraction 2nd Grp
19-1911G	Blumberg Ribner CY 2013 Medicare HMO Part C Days-Medicaid Fraction 2nd Grp

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 21, 2019 request for expedited judicial review ("EJR") (received May 22, 2019[1]), for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[2]

[1] The Board sent a Request for Information in these two group appeals on June 19, 2019, which stayed the 30-day period for the Board to respond to the EJR requests in these appeals. The Board requested that the Providers' representative tconfirm whether the group appeals for Case Nos. 19-1909G and 19-1911G are challenging only the FFY 2005 Part C Days SSI Policy and, as a result, are only seeking relief with respect to those Part C Days occurring prior to October 1, 2013. In its response dated June 18, 2019, the Providers' representative confirmed that the two groups are only challenging FFY 2005 Part C Days SSI Policy and are only seeking relief with respect to those Part C Days occurring prior to October 1, 2013. There is no dispute with respect to the Part C Days occurring on or after October 1, 2013.

[2] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . . (emphasis added)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[11]

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[12] 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

[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[13]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[14]

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[16]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[17]

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."[18] In response to a comment regarding this change, the Secretary explained that:

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[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] 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.
[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[21] 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."[22]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[23] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy

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[19] *Id.*
[20] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[21] 72 Fed. Reg. at 47411.
[22] 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).
[23] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[24] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[25] 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*.[26] 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.[27] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

Decision of the Board

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

Jurisdictional Determination

The participants in this EJR request have filed appeals involving the 2013 cost reporting period. Based on the Providers' representative's response to the Board's Request for Information, the period at issue for these appeals is through 9/30/2013. There is no dispute with respect to the period from 10/1/2013 through 12/31/2013 at issue in this EJR determination for those Providers with a 12/31/2013 fiscal year end.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of

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[24] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[25] 863 F.3d 937 (D.C. Cir. 2017).
[26] *Id.* at 943.
[27] *Id.* at 943-945.

Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[28] 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.[29]

On August 21, 2008, new regulations governing the Board were effective.[30] 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).*[31] 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.[32]

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

The Board has determined that the participants' appeals involved with the instant EJR Request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[33] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the underlying participants.

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[28] 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.).
[29] *Bethesda at 1258-59.*
[30] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[31] 201 F. Supp. 3d 131 (D.D.C. 2016)
[32] *Banner* at 142.
[33] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2013 cost reporting period (through 9/30/2013), thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g*., only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject years for the Providers and that the Providers are entitled to a hearing before the Board;

2) based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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

FOR THE BOARD:

7/9/2019

X Charlotte F. Benson

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

Enclosures: Schedules of Providers

cc: Danene Hartley, National Government Services, Inc.
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

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

17-2001GC Dignity Health 2005 Exclusion of Dual Eligible Part C Days – Medicaid Ratio CIRP

Dear Mr. Chinea:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 10, 2019 request for expedited judicial review ("EJR") of the above referenced appeal.[1] The Board's jurisdictional determination and decision regarding the EJR request is set forth below.[2]

Issue in Dispute

The issue in this appeal is:

> [W]hether Medicare Part C patients are 'entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[3]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] The May 10, 2019 Request for EJR included 15 other groups: 14-1290GC; 16-1311GC; 16-1729GC; 16-1731GC; 16-2064GC; 16-2065GC; 16-2118GC; 17-0541GC; 17-0542GC; 17-1397GC; 17-1928GC; 17-2016GC; 17-2052G; 17-2072G; and 18-0168G. The Board issued a decision granting EJR in this appeals on June 6, 2019.
[2] On June 6, 2019, the Board sent a Request for Information to the Providers' representative, Toyon Associates, Inc. ("Toyon"), and to the Medicare Contractor. The Board asked both parties for additional information with respect to the Provider in the group that has a fiscal year that *begins* in federal fiscal year ("FFY") 2004 ***and*** *ends* in FFY 2005. In this letter, the Board gave both parties 30 days to respond, and indicated that the request for additional information stayed the 30-day period for responding to the EJR request. Toyon submitted its response on July 8, 2019. The Medicare Contractor submitted its response on June 20, 2019. In its response, Toyon indicated that the Provider's fiscal year at issue that appeared to begin in FFY 2004 did not; the Provider is appealing the period from 1/1/2005 – 6/30/2005, therefore neither of the Providers in the group is appealing a FFY that began in FFY 2004.
[3] Providers' EJR Request at 4.

prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[6] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[12]

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the

[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
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[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[11] Emphasis added.
[12] 42 C.F.R. § 412.106(b)(2)-(3).

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[13]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[14]

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[15] 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].[16]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[17]

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[13] Emphasis added.
[14] 42 C.F.R. § 412.106(b)(4).
[15] of Health and Human Services.
[16] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[17] *Id.*

With the creation of Medicare Part C in 1997,[18] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[19]

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

> [O]nce a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .* [20]

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."[21] In response to a comment regarding this change, the Secretary explained that:

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

[18] 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.
[19] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[20] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[21] 69 Fed. Reg. at 49099.

> the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[22]

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

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The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[26] 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.[27] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[28] 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*.[29] 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.[30] Once again, the Secretary has not acquiesced to this decision.

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[22] *Id.* (emphasis added).
[23] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[24] *Id*. at 47411.
[25] 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).
[26] 746 F. 3d 1102 (D.C. Cir. 2014).
[27] *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.").
[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.

Providers' Request for EJR

The issue under appeal in this case involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[31] In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdiction for the Group Participants

The participants that comprise the group appeals within this EJR request have filed appeals involving the 2005 cost reporting period. Based on the Providers' representative's July 8, 2019 response to the Board's Request for Information, the period at issue for these appeals does not involved FFY 2004.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of

[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.

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*").[33] 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.[34]

On August 21, 2008, new regulations governing the Board were effective.[35] 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*").[36] 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.[37]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[38]

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[33] 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.).
[34] *Bethesda*, 108 S. Ct. at 1258-59.
[35] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Id.* at 142.
[38] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants' appeals involved with the instant EJR Request are governed by the decision in *Bethesda*. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[39] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeal.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

[39] *See* 42 C.F.R. § 405.1837.
[40] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[41] *See* 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

For the Board:

7/10/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

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Michael Ostrander, Chief Financial Officer
Nathan Littauer Hospital
99 East State Street
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Pam VanArsdale, Appeals Lead
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Nathan Littauer Hospital
Provider No. 33-0276
FYE 12/31/2016
PRRB Case Number 19-1851

Dear Mr. Ostrander and Ms. VanArsdale:

The Provider Reimbursement Review Board (the Board) recently reviewed the subject appeal and notes an impediment to the Board's jurisdiction. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Medicare Contractor issued an Interim Determination to the Provider on the Medicare-dependent hospital's ("MDH's") Volume Decrease Adjustment (Interim Determination) for FYE 12/31/2016 on November 15, 2018. The Provider filed an appeal from the Interim Determination on March 27, 2019. In its appeal request, the Provider indicates it is appealing ". . . timely, prior to the 180 day timeframe from receipt of the Notice of Final Determination."[1]

The Interim Determination specifically states ". . . you may also formally appeal this determination in accordance with CMS Pub. 15-1, Chapter 29 **once the final notice has been sent**" (emphasis added.)[2]

42 C.F.R. § 412.108(d)(2) indicates that a MDH must submit a request for payment adjustment within 180 days of the date on the Medicare Contractor's Notice of Program Reimbursement ("NPR"). The Medicare Contractor then makes its determination within 180 days of receipt of the hospital's request.

[1] Provider's Appeal Request at 1 (March 27, 2019).
[2] MDH Volume Decrease Adjustment –Interim Determination (Nov. 15, 2018).

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the **final** determination.[3]

As noted above, 42 C.F.R. § 412.108(d)(2) requires that a MDH request a payment adjustment (based on a decrease in discharges) to the Medicare Contractor within 180 days of the date of the issuance of its NPR. In accordance with 42 C.F.R. § 412.108(d)(3) the Medicare Contractor has 180 days from of receipt of the Provider's request (and all supporting documentation) to make it final determination. Based on 42 C.F.R. § 412.108(d)(3)(iii) it is that final decision that can be appealed directly to the Board. The November 18, 2018 determination was clearly marked as "interim." This determination is clearly not the "final" determination from which the Provider can file a timely appeal under 42 C.F.R. § 412.108(d)(3)(iii). Therefore, the Board finds that this appeal request is premature and dismisses the case.

Board Members Participating:

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

For the Board:

7/10/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

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

[3] Emphasis added.

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Bruce Snyder
Novitas Solutions, Inc.
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: **Jurisdictional Decision**
Provider Name: Howard University Hospital
Provider No.: 09-0003
FYE: June 30, 2013
PRRB Case No.: 17-0593

Dear Mr. Putnam and Mr. Snyder,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the MAC's Jurisdictional Challenge over Howard University Hospital's ("Hospital" or "Provider") individual appeal from its revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Provider was issued a revised NPR on September 29, 2016, for fiscal year end ("FYE") 6/30/2013. On December 6, 2016, the Provider filed an appeal request with the Board that identified three issues:[1]

1) Medicaid Eligible Medicare Unmatched Days – Provider challenges the exclusion of days pertaining to patients with Medicaid coverage and initially identified as Medicare recipients from the calculation of the Provider's Medicaid ratio used in the determination of the Providers Operating Disproportionate Share Hospital (DSH), Low Income Payment (LIP), and Capital Disproportionate Share Hospital adjustment calculations;
2) Unmatched Medicaid Days – Provider contends that the Medicaid fraction of its Operating DSH and Capital DSH adjustment calculations has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 C.F.R. 412.106;
3) IME/GME Adjustment Amount – To adjust the per resident amounts is correct with respect to the adjustment to the per resident amount for

[1] Provider's Request for Hearing, PRRB Case No. 17-0593 (Dec. 6, 2016).

> "Other". The provider believes that the per resident update factors have not been properly computed.[2]

The MAC filed a Jurisdictional Challenge over all three issues on April 18, 2018.[3] The Provider transferred issue number 2 (Unmatched Medicaid Days) into group case, PRRB Case No. 17-0227G, before any decision was made on the MAC's initial Jurisdictional Challenge in this individual case. Issue number 2 was transferred into Case No. 17-0227G, and the Board has ruled on the jurisdictional challenge in the group appeal. [4] Only issues one and three remain.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor argues that the Board does not have jurisdiction over Medicaid Eligible Unmatched Days and the IME/GME adjustment amount, because neither of these issues were adjusted in the Provider's revised NPR. The Provider cites audit adjustments 3, 5, and 6, as the source of its dissatisfaction for issue 1, the Medicaid Eligible Medicare Unmatched Days.[5] The Provider cites audit adjustment 3 as the source of its dissatisfaction for issue 3, IME/GME Adjustment Amount.[6] Adjustments 3, 5, and 6, relate to a change in bed days available.[7] The MAC argues that these adjustments have no relation to Medicaid Eligible Medicare Unmatched Days or IME/GME Adjustment Amount identified in issues 1 and 3. Additionally, the MAC did not adjust the Medicaid Eligible Medicare Unmatched Days or IME/GME Adjustment Amount during the cost report revision to which the Revised NPR applies.[8]

As the MAC made no adjustment to the cost report, the MAC argues that they did not render a final determination over any of the issues raised by the Provider, including issues 1 and 3 in this current appeal. As such, the PRRB lacks jurisdiction over these issues.

Provider's Jurisdictional Response

The Provider has not filed a jurisdictional response.

Board's Analysis and Decision

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

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

[2] *Id*.
[3] *See* MAC's Jurisdictional Challenge, Ex. I-1 (May 17, 2018).
[4] MAC's Jurisdictional Challenge (May 17, 2018).
[5] *Id*., Ex. I-1 at 2.
[6] *Id*.
[7] *Id*.
[8] *Id*.

> intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

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

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

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

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

The Board finds that it does not have jurisdiction over Howard's appeal from a revised NPR, for the Medicaid Eligible Medicare Unmatched Days or IME/GME Adjustment Amount, as they were not specifically adjusted in the Provider's revised NPR. The Medicare Contractor made no adjustments to Medicaid Eligible Medicare Unmatched Days or IME/GME Adjustment Amount and only adjusted the previously identified items 3, 5, and 6, bed days available.[9]

Once the RNPR was issued, the Provider appealed the exclusion of Medicaid eligible recipients' whose coverage had not been matched at the time of the audit.[10] As this were not part of the reopening appealed (no adjustments to this component), the Board lacks jurisdiction from a revised NPR. Had the Provider wanted to appeal Medicaid Eligible Medicare Unmatched Days or the IME/GME Adjustment Amount, it could have appealed those issues from the original NPR.

The revised NPR regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. The Provider has appealed Medicaid Eligible Medicare Unmatched Days and the IME/GME Adjustment Amount, which were not adjusted in the revised NPR. The Board hereby denies jurisdiction over these issues. As these are the final two remaining issues, the case will be closed.

[9] MAC's Jurisdictional Challenge, Ex. I-1 at 2.
[10] *Id.*, Ex. I-1 at 27.

Board Members Participating:

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For the Board:

7/10/2019

X Charlotte F. Benson

Charlotte F. Benson
Board Member
Signed by: PIV

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

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Laurie Polson
National Government Services, Inc.
MP: INA 101-AF42
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Indianapolis, IN 46206

RE: Jurisdictional Determination
Affinis Hospice Jesup, LLC
Provider No.: 11-1781
FYE: 2019
PRRB Case No.: 19-0447

Dear Ms. Ridley and Ms. Polson:

This case involves Affinis Hospice, LLC's ("Affinis" or "Provider") appeal of its Notice of Program Reimbursement regarding fiscal year ending ("FYE") 2019. Following review of the individual appeal, the Board finds that it does not have jurisdiction as the total amount in controversy is less than $10,000 and must dismiss its appeal, as explained below.

Background

On December 4, 2018, the Board received Affinis' appeal of CMS' determination to reduce the Provider's annual payment update ("APU") for Fiscal Year ("FY") 2019, for failure to fully meet the requirements of the Hospice Quality Reporting Program ("HQRP").

On March 27, 2019, the Board requested further Calculation Support from the Provider, noting that, "[t]he amount in controversy calculation was based on payments for the period 7/1/2018 - 10/31/2018. Please provide documentation of payments for the fiscal year in dispute, currently 10/1/2018 - 3/31/2019."[1] Affinis responded to the Board's request providing an estimated amount in controversy of $9,671.54.

Analysis and Recommendation

The Board finds that it does not have jurisdiction over this appeal because it does not meet the $10,000 threshold required for Board jurisdiction. Pursuant to 42 U.S.C. § 1395oo(a)(2) and

[1] Case Acknowledgment and Critical Due Dates Letter (Mar. 27, 2019).

42 C.F.R. § 405.1835(a)(2), a provider has a right to a hearing before the Board with respect to a final contractor or Secretary determination if: 1) it is dissatisfied with the final determination of the total amount of reimbursement due the provider; 2) the amount in controversy is $10,000 or more; and 3) the request for a hearing is received by the Board within 180 days of the date of receipt of the final determination.

Based on the Provider's appeal request, it is clear that the estimate amount in controversy in this case of $9,671.54 does not meet the $10,000 threshold required for an individual appeal.[2] Therefore, the Board finds that it lacks jurisdiction over this case and dismisses the above-referenced appeal for failure to comply with the amount in controversy requirement.

However, since the amount in controversy in this appeal is at least $1,000, but less than $10,000, the Provider may be entitled to a Medicare contractor hearing pursuant to 42 C.F.R. § 405.1809. Therefore, the Board shall refer the appeal request to the Medicare contractor hearing officer for consideration.

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

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

7/10/2019

X Charlotte F. Benson

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

cc: Wilson Leong, Federal Specialized Services

[2] *See* Provider's Calculation Support.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Sue Liu
Beaumont Health
26935 Northwestern Highway
Southfield, MI 48033

RE: ***Jurisdictional Decision***
Beaumont Hospital – Trenton (Provider No. 23-0176)
FYE 12/31/2014
Case No. 18-0921

Dear Ms. Liu,

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

Pertinent Facts:

Beaumont Hospital – Trenton ("Provider") filed their appeal request on February 20, 2018, appealing its Notice of Program Reimbursement ("NPR") issued on September 15, 2017, for Fiscal Year Ending December 31, 2014.[1] The appeal originally contained two issues, namely whether the Medicare Administrative Contractor ("MAC") properly determined the Provider's Medicaid eligible days, and whether the MAC properly determined the Provider's UCC payment.[2] On March 8, 2019, the Provider withdrew the Medicaid eligible days issue, leaving only the UCC payment issue.

The Provider is challenging the calculations used by the Secretary to determine their DSH UCC payment amounts for Federal Fiscal Year 2014. The Provider contends that there are flaws in determining its UCC payment including, but not limited to, invalid treatment of Medicare Advantage days, lack of transparency in the calculation, and that the best available data has not been used. They claim that Factor 1[3] may be understated due to CMS' current policy on the counting of patient days for individuals who receive Medicare benefits through enrollment in a Medicare Advantage Plan under Part C of the Medicare program. For Factor 2, Provider claims that the estimate used by CMS may not reflect the actual data, resulting in a lower Factor 2 adjustment. Finally, the Provider claims that Factor

[1] Individual Appeal Request, Tab 1 (Feb. 20, 2018).
[2] *Id.* at Tab 3.
[3] The UCC payment is made up of three factors: (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.

3 is based on stale data related to the number of its Medicaid and Medicare/SSI patient days, and that more accurate data is available subsequent to the calculation of Factor 3.[4]

The MAC filed a jurisdictional challenge on April 8, 2018, claiming this issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3), 42 C.F.R. § 412.106(g)(2).[5] They emphasize that the estimates used by the Secretary, as well as the underlying data used to generate those estimates, are both precluded from review and that the Board should dismiss this appeal as it lacks the authority over the issue.[6] The Provider has not filed a response to the jurisdictional challenge.

Board's Decision:

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[7]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit[8] upheld a D.C. District Court decision in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*")[9] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit 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 Tampa General's argument that it could challenge the underlying data, finding that there cannot

[4] Individual Appeal Request at Tab 3.
[5] *See* Medicare Administrative Contractor Jurisdictional Challenge (Apr. 12, 2018).
[6] *Id.* at 3.
[7] 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.
[8] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[8]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[9] 89 F. Supp. 3d 121 (D.D.C. 2015).
[10] 830 F.3d 515, 517.

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 Board finds that the same findings are applicable to the Provider's challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2014. The Board finds that in challenging the MAC's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. In fact, some of the Provider's arguments rest specifically on the fact that the estimates may not reflect "actual data."[12] The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.[13]

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

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

Board Members Participating:

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For the Board:

7/11/2019

X Clayton J. Nix

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

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

[11] *Id.* at 519.
[12] Individual Appeal Request at Tab 3 ("As a result, the estimate [sic] uninsured rate for Federal Fiscal Year 2014 may be higher than actual data.").
[13] The Board notes that D.C. Circuit revisited uncompensated care payments in a subsequent case and essentially reaffirmed its holding in *Tampa General*. *See DCH Reg. Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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VIA ELECTRONIC DELIVERY

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WPS Government Health Administrators
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Re: Southside Regional Medical Center (Provider No. 49-0067)
FYE 02/28/2010

Dear Mr. Hettich and Mr. Lamprecht:

The Provider filed this individual appeal with the Provider Reimbursement Review Board ("Board") on September 12, 2013. The Provider is appealing an original Notice of Program Reimbursement ("NPR") dated March 11, 2013, which was issued for the cost reporting period ending February 28, 2010 ("FY 2010"). The Provider stated two issues in their request for appeal. The Medicare Contractor has challenged jurisdiction over Issue No. 1 regarding the Allied Nursing Health Managed Care Payment. The Board reviewed the jurisdictional documentation in Case No. 13-3509 and, as set forth below, has determined that it lacks jurisdiction over this issue.

Medicare Contractor's Position

The Medicare Contractor filed a Jurisdictional Challenge (Aug. 30, 2018) which asserts that it did not render a final determination regarding Issue No. 1 addressing Allied Nursing Health Managed Care Payment. The Medicare Contractor points to the adjustment cited by the Provider, Adjustment No. 24, and alleges it does not render a final determination regarding the issue as required by 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835. The Medicare Contractor also contends that the Allied Nursing Health Managed Care Payment was omitted from the cost report as explained by the Provider in the Request for Appeal.

The Medicare Contractor argues the Provider has not preserved its right to claim dissatisfaction with this issue pursuant to 42 C.F.R. § 405.1835(a)(1)(ii). The Medicare Contractor's position is that the Provider was required to follow the applicable procedure for filing this cost report under protest, and the Provider did not establish a self-disallowed protest item for the disputed issue.

The Medicare Contractor adds that this issue does not fall under CMS Ruling 1727-R because the Provider is not legally challenging the validity of a regulation or payment policy.

Provider's Position

The Provider filed a Jurisdictional Response (Oct. 1, 2018) in which it claims it was improperly reimbursed for managed care costs incurred through its Nursing and Allied Health Program on Worksheet E, Part A, Line 11.01 of its cost report. The Provider contends the Board has jurisdiction over this issue as it was properly protested on Worksheet E, Part A, Line 30 in the amount of $309,185. The Provider explains this amount (along with other protested items totaling $2,313,262) were removed by the Medicare Contractor via audit Adjustment No. 25, and that the Provider inadvertently reference Adjustment No. 24 in its Request for Appeal.

The Provider's position is that it was the Medicare Contractor's responsibility to report the Allied Nursing Health Managed Care Payment on Line 11.01 of Worksheet E, Part A on the cost report pursuant to a CMS Program Memorandum entitled "Transmittal A-03-043, C.R. 2692 (May 23, 2003)." The Provider states the Transmittal instructs the Medicare Contractor to report the Allied Nursing Health Managed Care Payment on the cost report, not the Provider.

The Provider also asserts that, even if the Medicare Contractor is correct that the Provider did not properly protest this cost item or report it on the cost report, the Provider has a right to a hearing under *Bethesda Hospital v. Bowen*, 485 U.S. 399 (1988) because it is dissatisfied with the final determination on the cost report at issue.

Board Decision

A. Applicable Statues and Regulations

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

A provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy…[1]

The applicable procedures for filing a cost report under protest in the Provider Reimbursement Manual, CMS Pub. 15-2 ("PRM 15-2"), § 115.1 state:

> 115.1 Provider Disclosure of Protest.--When you file a cost report under protest, *the disputed item **and** amount **for each issue** must be specifically identified* in footnotes to the settlement worksheet and the fact that the cost report is filed under protest must be disclosed.
>
> 115.2 Method for Establishing Protested Amounts.--The effect of each nonallowable cost report item is estimated by applying reasonable methodology which closely approximates the actual effect of the item as if it had been determined through the normal cost finding process. In addition, *you must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable*. The cumulative effect on reimbursement for all disputed issues is shown as an adjustment to balance due to the program (provider) in the reimbursement settlement computation. The actual effect on reimbursable cost(s) is determined after final adjudication of the issue(s).[2]

The jurisdictional issue presented here is whether Southside preserved its right to claim dissatisfaction with a final determination. In this case, the Medicare Contractor argues that the Provider was required to claim or protest the payment in order to be entitled to a Board hearing. The Medicare Contractor states that the cost report instructions say that the Provider must obtain and report the amounts for cost report Worksheet E, Part A, Lines 11.01 and 11.02 (related to

[1] 42 C.F.R. § 405.1835(a)(1)(2012).
[2] (Italics and bold emphasis added and underline emphasis in original.)

Nursing and Allied Health) by contacting its Medicare Contractor. The Provider argues that it protested this item, and that it is the Medicare Contractor's responsibility to populate Worksheet E, Part A, Line 11.01 pursuant to Transmittal A-03-043, C.R. 2692 (May 23, 2003) and cost report instructions.

B. Analysis and Jurisdictional Determination

The Provider is appealing from a FY 2010 cost report, which means that, pursuant to 42 C.F.R. § 1835(a)(1) (2010) it either had to either claim or protest the cost at issue on the cost report in order for the Board to have jurisdiction.

At the outset is clear that the Provider had an obligation to claim the Allied Nursing Health Managed Care Payments at issue but failed to do so. Hospitals that operate a nursing or an allied health program may qualify for additional payments related to their Medicare Advantage enrollees under 42 C.F.R. § 413.87.[3] In order for an eligible hospital to receive the additional payment amount through its cost report, it must submit no-pay bills for Medicare Advantage enrollees to the contractors so that the inpatient days can be accumulated on the Provider Statistics & Reimbursement (PS&R) Report.[4] In addition to submitting the claims to the PS&R report, hospitals must properly report Medicare Advantage inpatient days on the Medicare cost report.[5] CMS's Cost Report Instructions for the cost reporting period under appeal give, in pertinent part, the following instructions to providers for Worksheet E, Part A:

> *Obtain* the payment amounts for lines 11.01 . . . from *your* fiscal intermediary [*i.e.*, Medicare contractor].
>
> Line 11.01--*Enter* the amount of Nursing and Allied Health Managed Care payments if applicable.[6]

These cost report instructions clearly state that it is the *Provider's* duty to obtain the information from its Medicare contractor and then enter the relevant amount on Worksheet E, Part A, Line 11.01. However, contrary to these instructions, the Provider did not include a claim for these costs on its as-filed cost report. Further, the Transmittal to which the Provider refers only addressed the implementation of *2001* ***and*** *2002* tentative and final cost reports, and the

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[3] CMS Manual System, Pub. 100-04, Transmittal No. 1472 at 41 (Mar. 6, 2008) (*available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1472CP.pdf).
[4] *Id*.
[5] *Id*. at 42.
[6] PRM 15-2, Ch. 36, Transmittal 14, at § 3630.1 (Apr. 2005) (revising PRM 15-2, Ch. 36, § 3630.1) (emphasis added) (*available at* https://www.cms.gov/ Regulations-and-Guidance/Guidance/Transmittals/downloads/R14P236.pdf).

Transmittal was "discarded after May 23, 2004."[7] It clearly does not address or apply to the fiscal year end under appeal which is 2010 (roughly 6 years after that Transmittal had been discarded).

In addition, the Board finds that the Provider did not protest these costs on its cost report as self-disallowed as required by 42 C.F.R. § 405.1835(a)(1)(ii). The instructions at PRM 15-2 § 115.1 clearly state that the provider must "specifically" identify "the disputed item *and* amount for *each* issue."[8] However, the documentation the Provider furnished does not adequately comply with these instructions. In the regard, the Board notes that the protested item referred to by the Provider as "Medicare HMO Days Used in Nursing Stlmt $309,185" addresses the number of HMO Days claimed without any reference to what costs in the nursing settlement the Medicare HMO days apply which in this case is purportedly the Allied Nursing Health Managed Care Payments.[9] Without information to the contrary, the Board must conclude that the Medicare HMO days protest item does not pertain to Allied Nursing Health Managed Care Payments because the protested amount listed does not correspond with that listed for the Allied Nursing Health Managed Care Payments issue which was stated in the appeal request as $470,495.[10] In this regard, the Board notes that there is no documentation in the record of how the protest amount was calculated contrary to the instructions in PRM 15-2 § 115.2. These instructions specify that the provider "*must submit*, with the cost report, *copies of the working papers used to develop the estimated adjustments* in order for the contractor/contractor to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable." Without this documentation, the Board is unable to determine what specific costs were associated with the protest item entitled "Medicare HMO Days Used in Nursing Stlmt $309,185." Finally, the Board notes that neither Adjustment No. 24 nor Adjustment No. 25 address the Allied Nursing Health Managed Care Payment issue, and the Medicare Contractor made no final determination regarding this issue.

Regarding the arguments pertaining to futility in claiming this cost because the data was not available from the Medicare Contractor, CMS Ruling 1727-R states that, if the provider's cost report did not claim reimbursement for the allowable item in the manner sought by the provider on appeal *and* the provider has not demonstrated a good faith belief that the item was not allowable, then the provider has not met the dissatisfaction jurisdictional requirement.[11] CMS

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[7] Provider's Jurisdictional Response (Oct. 1, 2018), Exhibit 1 at 7.
[8] (Emphasis added.)
[9] The Board notes that, in addition to Allied Health, the Medicare program uses Medicare HMO days data in the calculation of multiple other different costs including for example, disproportionate share payments, electronic health record payments, and graduate medical education payments (both direct and indirect).
[10] *See* Provider's Jurisdictional Response (Oct. 1, 2018), Exhibit 4. *See also* Provider's Model Form A – Individual Appeal Request (June 19, 2013), Tab 3 at 1.
[11] CMS Ruling 1727-R at 6-7.

Ruling 1727-R instructs the Board to then issue a jurisdictional dismissal decision.[12] The Board concludes that, since the relevant cost report instructions were clear (and the Transmittal referenced by the Provider was clearly not applicable), the Provider failed to demonstrate a "good faith belief" that the item was not allowable. Additionally, the Provider has not provided any evidence the data required on Worksheet E, Part A, Line 11.01 was not available from the Medicare Contractor or could not otherwise be claimed on the cost report consistent with the cost report instructions. Therefore, the Board finds that it is without jurisdiction to hear this issue.

In conclusion, the Board finds that the Provider has not preserved its right to claim dissatisfaction with the amount of Medicare payment for the Allied Nursing Health Managed Care Payment issue and, therefore, that it does not have jurisdiction over this issue. The Board hereby dismisses the Allied Nursing Health Managed Care Payment issue from Case No. 13-3509 for failing to meet the dissatisfaction requirement.

The case will remain open for resolution of another remaining issue. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 1877 upon final disposition of the appeal.

Board Members Participating:

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For the Board:

7/12/2019

X Clayton J. Nix

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Chair
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[12] *Id*. at 7.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

Community Health Systems, Inc.
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Vice President, Revenue Management
4000 Meridian Boulevard
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WPS Government Health Administrators
Mr. Byron Lamprecht
Supervisor – Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Merit Health Northwest Mississippi (Provider 25-0042)
FYE 12/31/2014
Case No. 17-1688

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 17-1688. The decision of the Board is set forth below.

Background:

The Provider has timely appealed a Notice of Program Reimbursement ("NPR") for FYE 12/31/2014 with the Board on December 21, 2016. The Provider appealed 11 issues and submitted its Preliminary Position Paper indicating that all issues except the SSI Provider Specific and Medicaid Eligible Days were being transferred to various group appeals, including the SSI Systemic errors issue to Case No. 17-0578GC (ORS HMA 2014 DSH SSI Percentage CIRP Group). The Medicare Contractor submitted a jurisdictional challenge on April 5, 2018 and the Board received the Provider's response to the challenge on May 4, 2018.

Medicare Contractor's Contentions:

The Medicare Contractor challenged jurisdiction over the following five issues: SSI Provider Specific, Medicaid Eligible Days, Medicare Managed Care Part C Days, Dual Eligible Days and Uncompensated Distribution Pool ("UCC").

A. SSI Provider Specific Issue

The Medicare Contractor contends that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue. The Medicare Contractor suggested that, while the issue is suitable for reopening, it is not an appealable issue contending that, under the context of a SSI realignment request, a final determination has not been made from which the Provider can be dissatisfied and that, as a result, the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. [1] In conclusion, the Medicare Contractor asserts that the Provider may not appeal the realignment of its SSI percentage or attempt to leverage an appeal related to the validity of the SSI percentage by including the realignment as an appeal issue.[2]

B. Medicaid Eligible Days Issue

The Medicare Contractor asserts that Adjustment Nos. 5 and 7 do not furnish a final determination with respect to additional days for which the Provider cited as a source of dissatisfaction. Further, Adjustment No. 5 updated the SSI ratio and does not impact the Medicaid ratio. Adjustment No. 7 updates worksheet S-3, part 1 to reflect the Provider's PS&R. Accordingly, the Medicare Contractor concludes that the Provider has failed to show a determination over additional Eligible Days.

C. Medicare Managed Care Part C Days and Dual Eligible Days Issue

The Medicare Contractor contends that the Medicare Managed Care Part C Days issue is duplicative of both the SSI and Medicaid Fraction Part C Days issues, and the Dual Eligible Days issue is duplicative of both the SSI and Medicaid Fraction Dual Eligible Days issues. [3]

D. UCC Issue

The Medicare Contractor challenged jurisdiction of the UCC issue and on February 21, 2018 the uncompensated care issue was transferred to case number 17-0573GC. Therefore, the Board will not address this challenge in this individual appeal.

[1] Medicare Contractor's Jurisdictional Challenge at 2-3.
[2] *Id*. at 4
[3] *Id.* at 4-5.

Provider's Contentions:

A. SSI Provider Specific Issue

The Provider asserts that the Medicare Contractor is incorrect its contention that the DSH/SSI realignment issue is not an appealable issue.[4] The Provider contends that it is addressing the realignment of the SSI percentage, but it is also addressing varying errors of omission and commission that do not fit within the systemic errors category. The Provider contends that this is an appealable issue because the Medicare Contractor adjusted the SSI percentage and the Provider is dissatisfied with the amount of DSH payment that it received for fiscal year end as a result of the understated SSI percentage.

The Provider contends that, based on *Northeast Hospital Corporation v. Sebelius*, 657 F. 3d 1 (D.C. Cir. 2011), the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[5] Therefore, the Provider maintains that it can submit data to prove that its SSI percentage was understated.

B. Medicaid Eligible Days Issue

The Provider argues that the Board does have jurisdiction over the Medicaid Eligible Days issue because an adjustment was made to the DSH calculation on its cost report and this is sufficient to permit jurisdiction. The Provider contends that adjustments are not required, as DSH is not an item that even need be adjusted or claimed on a cost report.[6]

The Provider also contends that there were delays in receiving information from the state that served as a "practical impediment" to reporting all Eligible Medicaid Days for a given fiscal year related to the relevant cost report filing deadline.[7]

C. Medicare Part C and Dual Eligible Days Duplicate Issues

The Provider agrees that the Medicare Managed Care Part C Days issue is duplicative of both the SSI and Medicaid Fraction Part C Days issues, and the Dual Eligible Days issue is duplicative of both the SSI and Medicaid Fraction Dual Eligible Days issues. The Provider requests that the issues be consolidated.

[4] Provider's Jurisdictional Response at 2.
[5] *Id.*
[6] *Id.* at 3.
[7] *Id*. at 4.

D. UCC Issue

The Provider did not address the Board's jurisdiction over the UCC issue.

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

A. SSI Provider Specific Issue

The Board dismisses the Provider's SSI Provider Specific issue which relates to how the Medicare Contractor computed the SSI percentage because it is duplicative of the SSI Systemic Errors issue that was transferred to Case No. 17-0578GC. The DSH/SSI issue concerns "whether the Medicare Contractor used the correct SSI percentage in the DSH calculation."[8] The Provider's legal basis for its SSI Provider Specific issue is that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)." [9] The Provider contends that "its SSI percentage . . . was incorrectly computed . . . and it disagrees with the Medicare Contractor's calculation of the computation of the DSH percentage set for that 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's regulations."[10] The SSI Systemic Errors issue is "whether the Secretary properly calculated the Provider's DSH/SSI percentage." Therefore, the Provider's disagreement related to how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that was transferred to group appeal.

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

[8] *Id*. at 3, Issue 1.
[9] *Id*.
[10] *Id*.

B. Medicaid Eligible Days Issue

1. Background on the Applicable Regulations and CMS Ruling 1727

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. Regulation dictates that a provider must preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy…

However, recent developments have limited the application of preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1).

In 2016, the D.C. federal district court held in *Banner Heart Hospital v. Burwell* ("*Banner*")[11] that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy). The *Banner* court explained its decision as:

> [W]hen a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].[12]

[11] 201 F. Supp. 3d 131 (D.D.C. 2016).
[12] *Id.* at 141.

The *Banner* court looked to the Supreme Court's 1988 decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[13] which also addressed a challenge to a regulation which was not first presented to the Medicare contractor.[14] *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[15] The Supreme Court in *Bethesda* stated:

> [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.

In response to the *Banner* decision, CMS issued Ruling CMS-1727-R ("Ruling 1727") to set forth its policy to create an exception to the application of the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) consistent with (but broader than) the holding in *Banner*. Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[16]

2. Analysis of the DSH Medicaid Eligible Days Under CMS Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on December 21, 2016 and the appeal was open on April 23, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year

[13] 485 U.S. 399 (1988).
[14] *Banner*, 201 F. Supp. 3d at 141.
[15] *Bethesda*, 485 U.S. at 404.
[16] Ruling 1727 at unnumbered page 2.

end December 21, 2016 cost report, thus the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other 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."[17]

Under §§ 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—part of the Secretary's regulations mandate that a DSH-eligible hospital "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day."[18]

As the pertinent DSH regulations instruct that a provider is required to furnish Medicaid patient verification information to the Medicare contractor, and because the time frame within which a hospital must file its cost report is also set by regulation, the Board could find that the Provider's DSH Medicaid Eligible Days issue "was subject to a regulation or other 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."

In its appeal request, the Provider argues that the Medicare Contractor, contrary to regulation, failed to include all Medicaid eligible days in its DSH calculation.[19] In its response to the jurisdictional challenge, the Provider focuses on arguing that the presentment requirement is not valid and that DSH does not have to be claimed or audited to give rise to jurisdiction. The Provider also contends that "the documentation necessary to pursue DSH is often not available from the State in time to include all DSH/Medicaid Eligible Days. "Historically, the data needed by Providers from the state to verify Medicaid eligibility [including the eligibility of Part C Days patients] during a specific fiscal year often has not been available for months or even years after the cost report filing deadline for that fiscal year. This lack of availability and/or access to state data created a practical impediment to reporting all eligible Medicaid days (both paid and unpaid) for a given fiscal year at the time of the relevant cost report filing deadline."[20]

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable

[17] Ruling 1727 at 6.
[18] 42 C.F.R. § 412.106(b)(4)(iii) (2010).
[19] Provider's Appeal Request at Issue 7.
[20] *See* Provider Jurisdictional Response (May 3, 2018).

regulation.[21] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, the DSH Medicaid Eligible Days sought are *not* within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider's cost report, as required by regulation. In this regard, the Provider confirmed that it could only report on its as-filed cost report those Medicaid eligible days that had been verified with the relevant state and, accordingly, that the Provider self-disallowed any unverified days in accordance with Board Rule 7.2(B).[22]

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by the proof of eligibility regulation at 42 C.F.R. § 412.106(b)(4)(iii), and therefore the Board "not apply the self-disallowance jurisdiction regulation" in its jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider did not self-disallow the DSH Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that the DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification.[23] Only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

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[21] 42 C.F.R. § 405.1835(a) (2010).
[22] *See* Provider's Jurisdictional Response (May 3, 2018) at 4-5.
[23] For a thorough discussion of how the regulations bind and otherwise constrict providers and Medicare contractors in the reporting of Medicaid eligible days, *see* the Board"s decision in *Barberton Citizens Hosp. v. CGS Adm'rs, LLC*, PRRB Dec. No. 2015-D5 (Mar. 19, 2015), *declined review*, CMS Adm'r (Apr. 22, 2015).

C. Medicare Part C and Dual Eligible Days Duplicate Issues

The Board finds that issues five, Medicaid Fraction/Medicare Managed Care Days and issue eight, Medicare Managed Care Days are duplicative and are consolidated and transferred to group appeal, Case No. 17-0574GC. Likewise, issue six, Medicaid Fraction/Dual Eligible Days and issue nine, Dual Eligible Days are duplicative and are consolidated and transferred to group appeal, Case No. 17-0577GC.

D. UCC Issue

The Board finds that the UCC Distribution Pool issue was transferred to group appeal and, accordingly, will not address that issue and the associated transfer at this time.

Conclusion:

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue.

The Board does find that it has jurisdiction over the Medicaid Eligible Day issue based on the rationale in *Banner* and CMS Ruling 1727R for those days that could not be verified prior to when the cost report was filed as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification. The Board also finds that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

The Board finds that issues five and eight and issues six and nine should be consolidated as they are duplicative and transferred to Case Nos. 17-0574GC and 17-0577GC respectively.

The Board will not address the UCC Distribution Pool issue because it has been transferred to group appeal.

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

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

7/15/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Electronic Mail

Isaac Blumberg
Blumberg Ribner, Inc.
11400 W. Olympic Blvd, Ste. 700
Los Angeles, CA 900064-1582

RE: ***Request for Reconsideration of Expedited Judicial Review Denial***
MidState Medical Center (Provider No. 07-0017)
FYEs: 09/30/2009, 9/30/2010, 9/30/2011, 9/30/2012, 9/30/2013
Case Nos.: 14-0771, 15-0065, 15-2037, 15-2043, 16-1956

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (the "Board") is in receipt of your May 2, 2019 Request for Reconsideration of the Board's denial of expedited judicial review ("EJR") for the Medicare Advantage Days (Part C Days) issue in the above-referenced ***individual*** appeals on April 19, 2019. As set forth below, the Board hereby denies your request for reconsideration.

Background

The Provider, MidState Medical Center ("MidState") filed ***individual*** appeal requests with the Board for its cost reporting periods 9/30/2009 through 9/30/2013. For each of these five appeals, the Provider appealed three issues: Medicare/Medicaid Dual Eligible Patient Days; Medicare SSI Percentage; and Medicare HMO Days.[1] These issues remain pending in all five appeals.

The Provider's representative, Blumberg Ribner, Inc. submitted requests for EJR in the above-referenced ***individual*** appeals for MidState Medical Center on March 28, 2019[2] and April 8, 2019.[3] In reviewing the appeals, the Board noted that the Provider indicated that it was part of the Hartford Healthcare chain, which is an organization that has other hospitals that receive Disproportionate Share Hospital payments. The regulation at 42 C.F.R. § 405.1837(b)(1), requires that commonly owned or controlled providers file group appeals for each common issue of fact, law or rulings (*i.e.*, file common issue related party group appeals (CIRPs)). In light of this regulation, on April 19, 2019, the Board issued a decision in which it denied EJR for the above-referenced appeals because it needed additional information to be able to determine whether the Provider's appeals are structured properly (CIRP group appeals rather than as individual appeals). As part of the EJR denial, the Board requested the following information from the Provider Representative:

[1] For its fiscal year 2013 appeal, the Provider separately appealed the Medicare and Medicaid fractions for the dual eligible and HMO/Part C days issues, for a total of 5 issues.
[2] The EJR request for 14-0771, 15-0065, 15-2037, and 15-2043 was filed on March 28, 2019.
[3] The EJR Request for 16-1956 was filed on April 8, 2019.

> *For **each** fiscal year*, the Representative must notify the Board if there are other members of the Hartford Healthcare chain *which have a common issue* (*e.g.*, the Part C Days issue (which is the subject of the EJR request) as well as the Dual Eligible Days issue, and the Systemic SSI Fraction issue) and whether collectively they would meet the $50,000 threshold. If there are other providers in the chain with the common issue, then a CIRP group must be established for ***each*** *common issue* as required by regulation and the appropriate common issue must then be transferred from the Hartford Healthcare providers to that CIRP group appeal. In addition, for ***each*** CIRP group, you must indicate whether the CIRP group is fully formed or whether there are any other related Providers pursuing the issue. If the Provider believes there are no other chain providers with common issues, they must make that attestation.
>
> Specifically, with respect to the Part C Days issue, the CIRP group appeal for each fiscal year would be complete as filed *if* there are (or will be) no other participants. If there will only be one participant for a fiscal year, you may request to establish an issue-specific multi-year group by joining it with a Part C Days CIRP group covering another fiscal year. Once the Part C Days CIRP group for a fiscal year is fully formed (or you provide the attestation that no other provider has the issue under appeal for a specific year), you may resubmit the requests for EJR for the Part C Days issue under separate cover.[4]

Blumberg Ribner filed its one-page response to the request for information with the Board on May 2, 2019, in which it stated:

> In response to the PRRRB [*sic*] denial, we spoke with Quality Reimbursement Services (QRS), the other consultant involved with Hartford Health appeals, which is the parent of MidState. For the years in question, QRS informed us that there were no CIRP Medicare HMO Days Group Appeals established. Also, *since QRS has already requested EJR for the other Hartford Hospitals*, there are no other Hartford Health Hospitals available to create any CIRP Group Appeals. As such, we respectfully request the Board to reconsider its denial of our EJR request from the individual appeals.[5]

[4] (Underline emphasis added and bold italics emphasis in original.)
[5] (Emphasis added.)

Board's Decision

The Board finds that the Provider in the above-referenced appeals failed to meet the common issue requirements of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(b)(1). The applicable statute, regulation, and Board rules are all clear that commonly owned providers must form a CIRP group for appeals of common issues for the same cost reporting period that satisfy the amount in controversy requirements for groups.

42 U.S.C. § 1395oo(f)(1) requires that "[a]ny appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers." The regulation at 42 C.F.R. § 405.1837(b)(1) entitled "***Mandatory*** use of group appeals"[6] states:

> (i) Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must bring*** the appeal as a group appeal.[7]

The Board finds that MidState Medical Center did not meet the CIRP statutory and regulatory requirements and, therefore, upholds its April 19, 2019 denial of the EJR.

Moreover, in its April 19, 2019 letter, the Board requested specific information with respect to whether other members of the Hartford Healthcare chain were appealing common issues and would meet the $50,000 required to establish a CIRP group. The Board also stated, "If the Provider believes there are no other chain providers with common issues, *they **must** make that attestation*."[8] The Board's request for an attestation is grounded in Board Rule 12.10 which states:

> The person filing the appeal request on behalf of a group must certify the submission, specifically:
>
> • I certify that the group issue filed in this appeal is not pending in any other appeal for the same period for the same providers, nor has it been adjudicated, withdrawn, or dismissed from any other PRRB appeal.

[6] (Emphasis added.)
[7] (Emphasis added.) *See also* Board Rule 12.3.1 ("Providers under common ownership or control that wish to appeal a specific matter that is common to the providers *must bring* the appeal as a group appeal." (Emphasis added.)); Board Rule 19.2 ("Mandatory CIRP group appeals *must contain **all*** providers eligible to join the group which intend to appeal the disputed common issue." (Emphasis added.)).
[8] (Emphasis added.)

> - I certify to the best of my knowledge that there are no other providers to which these participating providers are related by common ownership or control that have a pending request for a Board hearing on the same issue for a cost reporting period that ends in the same calendar year covered in this request. See 42 C.F.R. § 405.1837(b)(1)(i).(This certification applies to optional groups only.)
>
> - I certify that I have read and am familiar with Board statutes, regulations, and rules and, to the best of my knowledge, the appeal is filed in full compliance with such statutes, regulations, and rules.
> - I am authorized to submit an appeal on behalf of the listed providers.

Blumberg Ribner did not specifically respond to any of the Board's requests. Instead, it submitted a vague response that it spoke with "the other consultant" that represents the Hartford Healthcare chain, and stated that EJR requests had already been filed for other Hartford Hospitals *relative to the Part C issue*. This does not meet the Board's requirement for an attestation and, in particular, does not confirm whether: (1) there are other Hartford Healthcare providers for which the Board either has granted EJR on the Part C issue for some or all for fiscal years ("FYs") 2009 through 2013 (the fiscal years at issue in the five cases for MidState); (2) there are other Hartford Healthcare providers which have appeals (individual or group) pending before the Board for some or all of FYs 2009 through 2013 for the Part C issue; and/or (3) there are other Hartford Healthcare providers who have not been issue an NPR for some or all of the FYs 2009 through 2013 and who intend to appeal the Part C issue once those NPRs are issued.

In addition to not adequately addressing the Part C issue, the response did not even address, much less mention, the Dual Eligible Days or Systemic SSI fraction issues. The Board's instructions in the request for information were clear:

> *For **each** fiscal year,* the Representative must notify the Board if there are other members of the Hartford Healthcare chain *which have a **common issue*** (*e.g.* the Part C Days issue (which is the subject of the EJR request) as well as the Dual Eligible Days issue, and the Systemic SSI Fraction issue) and whether collectively they would meet the $50,000 threshold. If there are other providers in the chain with common issues, then a CIRP group must be established for ***each** common issue* as required by regulation and the appropriate common issue must then be transferred from the Hartford Healthcare providers to that CIRP group appeal. In addition, for ***each*** CIRP group, you must indicate whether the CIRP group is fully formed or whether there are any other related

> Providers pursuing the issue. If the Provider believes there are no other chain providers with common issues, they must make that attestation.[9]

Based on the general statement that EJR requests have been filed and granted for other Hartford Hospitals and the *failure* of the Provider Representative to furnish an attestation with the requisite information, the Board must presume that there are other commonly-owned providers that appealed the same Part C issues (and of which previously requested and received EJR) and that, as a result, these Providers should have been in a CIRP group pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(b)(1). Further, based on the information provided by the Provider representative, the Board finds that MidState did not meet the mandatory CIRP statutory and regulatory requirements for any of the three issues in each appeal (Part C Days, Dual Eligible Days, or Systemic SSI Fraction issues) because the Provider Representative failed to furnish the Board with an attestation containing the requisite information pursuant to the Board's April 3, 2019 request for information.[10] Accordingly, the Board hereby denies the Request for Reconsideration of Expedited Judicial Review Denial and affirms is April 19, 2019 decision to deny EJR for Case Nos. 14-0771, 15-0065, 15-2037, 15-2043, and 16-1956. Additionally, the Board hereby dismisses the Part C Days issue, the Dual Eligible Days issue, and the Systemic SSI Fraction issue from these appeals because they should have been in a CIRP group pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(b)(1). As no issues remain pending, Case Nos. 14-0771, 15-0065, 15-2037, 15-2043, and 16-1956 are hereby closed and removed from the Board's docket.

Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877. Similarly, the Board notes that *a provider may request that the Board reinstate a dismissed case or issue pursuant to Board Rules 47 to 47.3*.

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For the Board:

7/16/2019

X Clayton J. Nix

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Signed by: Clayton J. Nix -A

cc: Pam VanArsdale, National Government Services, Inc.
Wilson C. Leong, Esq., CPA, Federal Specialized Services

[9] (Underline emphasis added and bold italics emphasis in original.)
[10] *See* 42 C.F.R. § 405.1868(b) (stating in pertinent part: "If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may – (1) Dismiss the appeal with prejudice . . . .").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Electronic Delivery

Michael G. Newell
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RE: EJR Determination

16-0425GC Southwest Consulting Einstein Health 2013 DSH Medicaid Fraction Part C Days
16-1821GC Southwest Consulting Crozer Keystone 2013 DSH SSI Fraction Part C Days Group
16-1822GC Southwest Consulting Crozer Keystone 2013 DSH Medicaid Fraction Part C Days
16-2041GC Care New England 2013 DSH Medicare/Medicaid Fraction Part C Days Group
17-0093GC SW Consulting Mem'l Herman 2014 Pre 10/1/2013 DSH Medicaid Fractn Part C Days Grp

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 19, 2019 request for expedited judicial review ("EJR") (received June 21, 2019) for the appeals referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

[1] This EJR request also included case number 15-1550GC. The Board will respond to the request for EJR in that case under separate cover.
[2] Providers' EJR Request at 4.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

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[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] 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.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[20] 69 Fed. Reg. at 49099.

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

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

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

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).

adopted in FFY 2005 IPPS rule.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] 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*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2013 and 2014 and *the period at issue for these appeals is **only** through 9/30/2013*.[31]

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

On August 21, 2008, new regulations governing the Board were effective.[34] 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*").[35] 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.[36]

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

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[31] Each of the providers in Case No. 17-0093GC have a fiscal year that ends 6/30/2014; however, only the first quarter of that fiscal year (i.e., 6/30/2013 through 9/30/2013) is at issue in this appeal. As a result of bifurcation, the providers have a separate CIRP group for the last three quarters of FYE 6/30/2014 for the Part C issue.
[32] 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.).
[33] *Bethesda*, 108 S. Ct. at 1258-59.
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016).
[36] *Id.* at 142.

appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[37] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The appeal of the revised NPR contained an adjustment to Part C Days as required for Board jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[38] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involves the 2013 and 2014 cost reporting periods *where the period at issue for these appeals is **only** through 9/30/2013*.[39] Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[37] See 42 C.F.R. § 405.1889(b)(1) (2008).
[38] *See* 42 C.F.R. § 405.1837.
[39] *See supra* note 31.
[40] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[41] *See* 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[42] and that the participants in these group appeals are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

Board Members Participating:

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

For the Board:

7/16/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bruce Snyder, Novitas (Electronic Mail w/Schedules of Providers)
Pam VanArsdale, NGS (Electronic Mail w/Schedules of Providers)
Justin Lattimore, Novitas (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

[42] *See supra* note 31.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Redington Fairview General Hospital (Provider No. 20-0012)
FYE 06/30/2005
Case No. 18-0215

Dear Mr. Stiles and Ms. VanArsdale,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

On October 29, 2015, Redington Fairview General Hospital ("Redington Fairview" or "Provider") submitted a VDA request to the Medicare Contractor. Redington Fairview requested a payment in the amount of $2,707,193 based on its *as-filed* FYE 06/30/2005 cost report as adjusted by the Medicare Contractor in June 2010.[1] However, at that time, the 06/30/2005 cost report had not been not finalized and, as a result, the Medicare Contractor calculated the VDA payment using the finalized 06/30/2004 and *as-filed* 06/30/2005 cost reports.[2]

On May 15, 2017, the Medicare Contractor issued its "MDH Volume Decrease Adjustment - *Interim* Determination" providing for "an *interim* adjustment amount" in the amount of $1,479,234 in response to the Provider's "*interim* request for a Medicare Volume Decrease Adjustment."[3] On November 2, 2017, the Provider filed its appeal from the *interim* determination with the Board. The Board assigned Case No. 18-0215 to this appeal.

[1] *See* Exhibit C-1 of the Medicare Contractor's Jurisdictional Challenge (Oct. 12, 2018).
[2] *See* Exhibit C-3 at 4 of the Medicare Contractor's Jurisdictional Challenge (Oct. 12, 2018) (stating "Provider submitted the Exception request on 10/30/2005. Request was filed timely as an *interim* VDA and based off the most recent NPR for 2004 and the as filed cost report for 6/30/2005. The 6/30/2005 file is not yet final." (Emphasis added.)).
[3] Exhibit C-2 of the Medicare Contractor's Jurisdictional Challenge (Oct. 12, 2018) (emphasis added).

Medicare Contractor's Position:

On October 12, 2018, the Medicare Contractor filed a jurisdictional challenge stating that the Provider failed to properly file an appeal based upon a *final* determination.[4] The Medicare Contractor argues that it made it "perfectly clear" to the Provider that the VDA determination was an *interim* determination and that the *interim* calculation would be reviewed once the Notice of Program Reimbursement ("NPR") was issued.[5]

Provider's Position:

Redington Fairview filed its Response to MAC's Jurisdictional Challenge on November 2, 2018. The Provider argues that the Medicare Contractor's position is untenable. The Provider asserts that it does not matter if the Medicare Contractor called the VDA payment "interim" or "final" because the Medicare Contractor would have made the same incorrect VDA calculation.[6]

Redington Fairview contends that assuming the VDA was not a final determination, the Medicare Contractor failed to issue a final NPR within 12 months from the filing of the FYE 06/30/2005 cost report. Therefore, 42 CFR 405.1835(c)(1) provides that a provider is entitled to a hearing if the Medicare Contractor does not issue a final determination within 12 months of the Provider filing its cost report.

Board Decision:

With regard to the Provider's appeal as it relates to the Volume Decrease Adjustment, the Board finds that the issue is premature as set forth below.

The Provider cites to 42 C.F.R. § 412.108(d) in its appeal request, which relates to the additional payments to hospitals experiencing a significant volume decrease. 42 C.F.R. § 412.108(d)(2) requires a Provider to submit its VDA exception to the Medicare contractor no later than 180 days *after the date of issuance of the Provider's* ***NPR***. The Medicare contractor then determines a lump sum adjustment amount. Pursuant to 405.108(d)(3)(iii), the Provider may appeal the Medicare contractor's VDA determination to the Board within 180 days of that determination.

In this case, the Provider requested a VDA exception from the Medicare Contractor for FYE 6/30/2015 and made that request prior to the issuance of the NPR for FYE 6/30/2015. In this regard, the Provider's request stated the following:

> Please note that the 2005 cost report has not been final settled at this time. We are filing this request using the adjusted cost report from the MAC's most recent adjustment report in June 2010.[7]

The Medicare Contractor issued an *interim* VDA payment determination on May 15, 2017. However, the Medicare Contractor had not yet issued an NPR for the FYE 6/30/2005 cost report.

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[4] Medicare Contractor's Jurisdictional Challenge at 2. (Oct. 12, 2018).
[5] *Id* at 1-2. Footnote 1 states "As of the filing of this Jurisdictional Challenge, the NPR for FYE 06/30/2005 has yet to be issued."
[6] Provider's Response to MAC's Jurisdictional Challenge at 1. (Nov. 2, 2018)
[7] Exhibit C-1 of the Medicare Contractor's Jurisdictional Challenge.

Nevertheless, the Provider submitted an appeal to the Board on November 2, 2017 attaching a copy of the May 15, 2017 *interim* determination and characterized is appeal as follows:

> The date of the Medicare Administrative Contractor's determination for the above cost reporting period is May 15, 2017. This appeal is being filed timely, prior to the 180-day timeframe from the receipt of the Notice of ***Final*** Determination. One issue is addressed herein: Volume Decrease Adjustment.
>
> The reimbursement impact for the ***final*** determination is $1,227,959 thereby meeting the $10,000 threshold necessary for PRRB jurisdiction.
>
> This request contains the following in support of this request for hearing:
>
> - Completed and Signed Model Form A – Individual Appeal Request
> - Tab 1 – Copy of ***Final*** Determination
> - Tab 2 – Representation Letter
> - Tab 3 – Statement of the Issue

The Medicare Contractor alleges that the Provider's request for appeal is not based on a final determination.[8] The Board agrees. It is clear that from the Provider's November 2, 2017 appeal request that it believed that it was appealing from a "final" determination and attached what it believed was the "final contractor or Secretary determination" as required by 42 C.F.R. § 405.1835(b)(3) (2017). However, as noted above, the determination at issue is clearly styled as an "interim" determination and only made an "interim adjustment amount" and, as such, was not a final determination as required under both 42 C.F.R. §§ 412.108(d)(3)(iii) and 405.1835(b)(3). This conclusion is supported by the fact that the *interim* determination did not lay out any appeal rights but rather states that "[p]lease note that when the cost report has been settled, this interim calculation will be reviewed to use final cost report numbers once the Notice of Program Reimbursement has been issued." Accordingly, the Board finds that the appeal request submitted on October 29, 2015 was premature because the Provider had not yet received the ***final*** determination on the VDA exception request from the Medicare Contractor prior to requesting a hearing with the Board as required by both 42 C.F.R. §§ 412.108(d)(3)(iii) and 405.1835(b)(3).

The Provider further argues that, if the Board finds the VDA determination is not final, it is still entitled to a hearing because the Medicare Contractor has not issued an NPR within 12 months. The Board rejects this argument on two separate grounds. First, the Board finds that the appeal rights in 42 C.F.R. § 405.1835(c) (2017) relating to the nonissuance of "[a] final contractor determination for the provider's cost reporting period . . . within 12 months after the date of receipt by the contractor of the provider's perfected *cost report* or amended *cost report*" is not applicable to VDA determinations. It is clear that § 405.1835(c) applies to final determinations *on the cost report* (*i.e.*, NPR) and not to VDA determinations which are made *separate* from the NPR and for which *separate* appeal rights are granted

[8] Medicare Contractor's Jurisdictional Challenge at 2. (October 12, 2018)

in 42 C.F.R. § 412.108(d)(3)(iii) but only as to the final VDA determination.[9] Moreover, even assuming *arguendo* that the Provider did have rights to appeal the nonissuance of a VDA determination, the Provider would have had to appeal that as a *separate* appeal issue and set that forth in an appeal request that met the time frame for appealing this issue. However, this issue was not timely identified and included in the initial appeal request or timely added to the appeal.[10] Accordingly, the Board rejects Provider's attempt to otherwise cure the Board's lack of jurisdiction through the new argument that it has appeal rights due to the Medicare Contractor's alleged failure to timely issue the VDA determination.

Accordingly, based on the analysis, the Board hereby dismissed the VDA payment issue from Case No. 18-0215. As the VDA payment issue is the only issue in the appeal, the Board hereby closes Case No. 18-0215. 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:

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For the Board:

7/17/2019

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

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

[9] In further support of this conclusion, the Board further notes that the regulations at 42 C.F.R. § 412.108(d)(3)(ii) set a 180-day standard for issuance of VDA determinations which is different that the 12-month standard for issuing NPRs as set forth in the Provider Reimbursement Manual, CMS Pub. 15-1, § 2905.1. *See* PRM 15-1 § 2905.1 (stating "The intermediary is to make every attempt to issue a NPR within 12 months of receipt of a cost report. Regulations provide that where the intermediary fails to render a determination within 12 months after receipt of the perfected (final) cost report, the provider (as defined in § 2900) may request a hearing before the PRRB, provided that (a) the cause of such delay does not lie with the provider and (b) the amount stated on the cost report as the amount of intended program payment due is at least $10,000 per cost report period."). *See also* 73 Fed. Reg. 30190, 30200 (May 23, 2008).

[10] Even if the November 2, 2017 appeal request had included the nonissuance of a VDA determination as an appealed issue, it is clear that it would not have been timely. 42 C.F.R. § 1835(c)(2) specifies that appeals from the nonissuance of an NPR must be made "no later than 180 days after the expiration of the 12 month period for issuance" of the NPR. While it is unclear when as-filed cost report for FY 2015 was filed, it is clear that it was filed prior to June 2010 (*see supra* note 7 and accompanying text) and any appeal from the nonissuance of an NPR for FY 2015 has long since expired. Similarly, even if the VDA determination were considered a determination to which 42 C.F.R. § 405.1835(c) were applicable, the November 2, 2017 appeal request would have not been timely as the time for appealing would have expired on or about April 27, 2017 (*i.e.*, roughly 12 months plus 180 days from October 29, 2015 if October 29, 2015 is assumed to be the date the Medicare Contractor received the VDA request).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination/Dismissal for Untimely Filing***
SSM Health St. Mary's Hospital Audrain (Provider No. 26-0064)
FYE 2014
Case No. 18-1851

Dear Mr. Zeman and Mr. Lamprecht:

This case involves SSM Health St. Mary's Hospital Audrain's ("St. Mary's" or "Provider") appeal of its Notice of Program Reimbursement ("NPR") regarding fiscal year ending ("FYE") 2014. Following review of the individual appeal, the Board finds that St. Mary's failed to file its Preliminary Position Paper ("PPP") in a timely manner and does not qualify for a good cause extension. Accordingly, as set forth below, the Board dismisses the Provider's appeal.

Pertinent Facts

On September 12, 2018, the designated representative submitted a *Request to Form Individual Appeal* ("RFH") based on a Notice of Program Reimbursement ("NPR") dated March 22, 2018. The appeal was filed timely based on the issuance of the NPR. The Board established Case No. 18-1851 and, *consistent with the Board's longstanding practice*,[1] sent the Letter of Acknowledgment and Critical Due Dates notice to the parties ***via email*** on October 2, 2018, stating that the Provider's PPP was due to the Board on May 10, 2019. This October 2, 2018 notice was also posted to the docket for Case No. 18-1851 on the Board's online filing and case management system referred to as "OH CDMS." Providers and Provider representatives have access to their case dockets on OH CDMS if they sign up for access.[2] Notwithstanding the October 2, 2018 notice, the Provider did not submit its PPP for Case No. 18-1851 by the stated May 10, 2019 due date.

[1] The Board has been sending Letters of Acknowledgment and Critical Due Dates Notices via email since May 2008.
[2] *See* Board Alert 14 (Aug. 16, 2018) ("The PRRB module of the Office of Hearings Case and Document Management System ("OH CDMS") is available for use. Users may access OH CDMS to file new appeals and all supporting documentation electronically and to review and maintain existing cases that are currently in an open status. *The PRRB notices and decisions will be issued* ***via email*** *and will also be accessible through OH CDMS*." (Emphasis added.)).

The Provider filed a Request for Extension on May 31, 2019, twenty one (21) days *after* the due date of the PPP had passed, stating:

> I respectfully request an extension to the Position Paper due date for the above referenced appeal for the reasons cited below which pertain to technical problems, primarily on the part of the PRRB, and which appear to be related to the *ongoing technical challenges* associated with the transition from the paper based system to the online filing and case management system, OHCDMS.[3]

The Provider gave the following description of the "ongoing technical challenges" with OH CDMS:

> The Provider filed two similar hearing requests for essentially the same issue (Low Volume Adjustment), for the same Provider, SSM Audrain Medical Center, but for different fiscal years (FY14 filed on September 11, 2018 and FY13, filed on September 24, 2018). This set the backdrop for confusion later on as to which fiscal year the PRRB correspondence pertained to, because the PRRB due date letter received by the Provider lacked the usual fiscal year designation, (in fact there was a line with "Fiscal Year", but next to it was a blank space).
>
> These LVA cases were each assigned difference case numbers, 18-1873, and 18-1851. One of these cases was assigned a due date of May 10, 2019, however the Provider was not aware of this May 10 date, likely due to PRRB email problems which prevented the Provider from receiving the email in a timely fashion. One of these cases was assigned a date of May 24, 2019, which the Provider was aware of via an Attachment, dated October 15, 2018 but sent January 8, 2019. Important to this request is the fact that the Provider did not know which FY pertained to the May 24 date because the due date notification from the PRRB was defective and lacked a fiscal year designation. Since at the point in time when the PRRB letter without a fiscal year arrived, no notice had been received for FY14 which had been filed first on September 11, 2018, the Provider incorrectly deduced the Jan 8 / October 15 notice was for FY14, the first year filed.

[3] (Emphasis added.)

The Provider further notes issues with email from the OH CDMS system:

> *The reason why the PRRB on January 8, 2019 sent an email with an October 15, 2018 attachment with the May 24th due date is not clear to the Provider.*
>
> It may be relevant that as the PRRB transitioned to its electronic system, it started sending correspondence from noreply@salesforce.com which triggered many provider's email filters. If the correspondence at issue was sent on October 2, 2018, then it likely was filtered out by the Provider's email system. However, *there is no simple way to establish that the PRRB letter was sent on October 2, 2018* or if it was initially filtered-out as spam, since, as is standard industry practice, email filters "purge" all spam emails, irretrievably which helps prevent system problems related to viruses potentially attached to spam.[4]

Notably, the Provider did not include the missing PPP with its filing of the Request for Extension.[5]

By way of background, Board Rule 2.2.2 address Board Correspondence and Decision Issuances and states that they will be sent via email to the parties:

> The Board will utilize OH CDMS to issue its correspondence via email to the parties of an appeal. That includes all types of correspondence, such as the Acknowledgement Letter, Notice of Hearing, requests for additional information or briefings, jurisdictional and substantive decisions, etc. When issued, an email will be sent to all parties with the referenced correspondence included as an attachment. A copy of the correspondence will also be maintained within OH CDMS for reference in accordance with CMS record retention policies.

Board Rule 5.2 address the responsibilities of representatives:

> The representative is responsible for ensuring his or her contact information is current with the Board, including a current email address and phone number. *The case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board* or the opposing party.

[4] (Emphasis added.)
[5] *See* Board Rule 47.3.

> *Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines*. Withdrawal of a case representative or the recent appointment of a new representative will also not be considered cause for delay of any deadlines or proceedings.

Board Rule 9 addresses Board Acknowledgement of Appeals and confirms that they will be sent via email to the parties and will establish various due dates and deadlines:

> The Board will send an acknowledgement via email to the designated representative indicating that the appeal request has been received and identifying the case number assigned. An acknowledgement does not limit the Board's authority to require more information or to dismiss the appeal if it is later found to be jurisdictionally deficient. If the appeal request does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action.
>
> The acknowledgment and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines (including deadlines established by a proposed joint scheduling order ("PJSO") per Rule 23.2) may result in the Board taking any of the actions described in 42 C.F.R. § 405.1868.

The Commentary accompanying Board Rule 9 specifies that the representative should contact the Board if he/she does not receive an acknowledgment letter with critical due dates from the Board within 30 days of filing an appeal request:

> *If the case representative has not received an acknowledgement letter from the Board establishing critical due dates **within 30 days** following the filing of an appeal request*, the representative should contact the Board at 410-786-2671.
>
> Per Rule 41.2, ***the Board may dismiss a case for failure to comply with any of the critical due dates*** and, therefore, it is imperative that the provider maintain current contact information on file with the Board (including an email address) per Rule 5.2.[6]

Board Rule 23.5 governs extension request for preliminary position papers and states:

> Requests for extensions for filing a . . . preliminary position paper must be filed *at least three weeks before the due date **and** will be*

[6] (Emphasis added.)

> *granted only for good cause*. If the Board has not notified the moving party before the due date that an extension is granted, and a . . . position paper is not timely filed, the appeal will be dismissed in accordance with Rule 23.4.

Analysis and Decision

The Provider expressed a number of concerns in its Request for Extension filed on May 31, 2019, including concerns regarding missing emails and missing FYE dates on Acknowledgment and Critical Due Date notices. As noted in the Request for Extension, the Board transitioned to it electronic system and began sending correspondence from a new email address, noreply@salesforce.com.[7] Consistent with the Commentary to Board Rule 9, in December 2018, the Provider representative's organization[8] informed Board staff *via email* that it believed that it was missing certain correspondence from the Board including acknowledgements and critical due date letters and asked that the Board resend the information. Specifically, the email stated the following:

> Lastly, we are missing (or believe we are missing) a number of acknowledgements and critical due date notifications that likely arrived starting early August through October. When the PRRB began using the new system, it appears they began relaying emails rather than sending them directly and the actual email that was used was a noreply@salesforce.com address. It is standard process for outlook to dump any emails containing "noreply" in the address into spam as these are usually spam or other clutter. I didn't realize this was happening until a couple weeks ago and anything that goes to spam is deleted permanently after 30 days as such all emails that we received prior to about 10/15 while the PRRB was using this process are gone and cannot be recovered. I have spoken with a number of people who all have this same issue, so I imagine this will be a problem for many representatives across the country. Is there anyway we can get a list of the correspondence that was sent out to date using this address? Or, more simply, a list of any due dates assigned since this new email address began being used. We currently have no way to determine if we have outstanding due dates of which we are not aware.

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[7] The Board's issuance of issued the Letter of Acknowledgment and Critical Due Dates Notice for Case No. 18-1851 ***via email*** is not a new practice or procedure. The Board has had a longstanding practice of issuing Letters of Acknowledgement and Critical Due Dates Notices ***via email*** as it began this practice over 10 years ago in May 2008. Rather, it was the email address from which those letters were being issued that changed in August 2018 when OH CDMS went live.

[8] The Provider representative, Mr. Zeman, is a vice president in his organization. The individual that contacted the Board is a manager in the same organization, Mr. Putnam.

The Board staff responded that all emails from the electronic system's ("OH CDMS") go-live in August 2018 through the end of October 2018 could be recovered and would be resent to the Provider representative's organization. On January 8, 2019, the Board sent an email to the email address specified by the Provider representative's organization confirming that this was being done:

> We have been able to recover prior emails sent from the Office of Hearings Case and Document Management System (noreply@salesforce.com; on behalf of; PRRB prrb_ohcdms@cms.hhs.gov) to appeals@srgroupllc.com. The emails date back to August 29, 2018. Per your request made to Kevin Keck, we will forward these emails in a series from that date through the end of October. If you have questions or require additional emails, please contact the help desk at helpdesk_ohcdms@cms.hhs.gov.

Board records confirm that the January 8, 2019 reissuance to the email furnished by the Provider representative's organization included the October 2 and 15, 2018 Case Acknowledgment and Critical Due Dates notices for Case Nos. 18-1851 ***and*** 18-1873 respectively. The Acknowledgment and Critical Due Dates notice for Case No. 18-1851 (the case at issue in this determination) identified *both* the Appeal period of 2014 *and* the PPP due date of May 10, 2019. The Acknowledgment and Critical Due Dates notice from Case No.18-1873 identified the PPP due date of May 24, 2019 but did not give the Appeal Period.

In its Request for Extension, the Provider representative claims there is no proof that the October 2, 2018 letter with the PPP due date of May 10, 2019 for Case No. 18-1851 was sent. Additionally, the Provider representative claims confusion because the Letter of Acknowledgment and Critical Due Dates Notice for Case No.18-1873 did not give the appeal period, just the PPP due date of May 24, 2019. As a result, the Provider representative claims that the Provider is without fault for not submitting its PPP timely for Case No. 18-1851 and askes the Board for an extension.

The Board disagrees that the Provider is without fault. The Board recognizes the lack of the Appeal Period on a Letter of Acknowledgement and Critical Due Dates Notice could potentially create confusion. However, the Board notes that any confusion on the Provider representative's part in identifying the FY in Case No 18-1873 could have easily been resolved by looking into the electronic case management system (*i.e.*, OH CDMS) or asking the Board staff. Indeed, this is what the commentary for Board Rule 9 recommends:

> *If the case representative has not received an acknowledgement letter from the Board establishing critical due dates* ***within 30 days*** *following the filing of an appeal request*, the representative should contact the Board at 410-786-2671.

> Per Rule 41.2, ***the Board may dismiss a case for failure to comply with any of the critical due dates*** and, therefore, it is imperative that the provider maintain current contact information on file with the Board (including an email address) per Rule 5.2.[9]

Finally, the record confirms that the Provider representative was able to resolve any potential confusion because the Provider representative did in fact timely submit the PPP for Case No. 18-1873 notwithstanding that missing appeal period.

More importantly, it was Case No. 18-1851 (not Case No. 18-1873) where the Provider failed to timely submit its PPP. Unlike the other case, the Letter of Acknowledgment and Critical Due Dates Notice for Case No. 18-1851 did ***clearly*** contain all the correct information including the appeal year (*i.e.*, FY 2014) and the PPP due date of May 10, 2019.

The Board also disagrees that there is no evidence that the October 2, 2019 Letter of Acknowledgment and Critical Due Dates Notice for Case No. 18-1851 was sent to the Provider representative *via email*. The Board recognizes the Provider representative's spam filters may have initially deleted the Board's emails sending these letters. Indeed, it is in recognition of this type of email issues that the Board included Commentary to Board Rule 9 to advise representatives to contact the Board if they have not received an acknowledgement letter with critical dues dates "***within 30 days*** following the filing of an appeal request" as the Board may dismiss a case for failure to comply with any critical due dates.[10] To this end, Board records confirm that, on December 10, 2018, the Provider representative's organization[11] contacted the Board by email to request, among other things, that the Board reissue certain acknowledgements and critical due date notifications that the Board sent in August through October using OH CDMS. Accordingly, on January 8, 2019, the Board reissued all notifications dated between August 29, 2018 and the end of October 2018 to the Provider representative's organization to the email address furnished by the Provider representative's organization. As previously noted, Board records confirm that, on January 8, 2019 (approximately *four months prior to* the PPP due date), the Board reissued the October 2, 2018 Acknowledgment and Critical Due Dates Notice for Case No. 18-1851 to the email address furnished by the Provider representative's organization.[12]

The email correspondence attached to the Provider representative's Request for Extension confirms that, on May 14, 2019, the Provider representative asked for yet a third copy of the October 2, 2018 Acknowledgment and Critical Due Dates Notice for Case No. 18-1851.[13]

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[9] (Emphasis added.)
[10] (Emphasis added.)
[11] *See supra* note 8.
[12] The Board notes that the Request for Extension appears to confirm that the Provider Representative received the January 8, 2019 reissuance of the Letter of Acknowledgment and Critical Due Dates Notice for Case No. 18-1873 which had the missing appeal period and which was reissued on May 14, 2019 with correction of the missing appeal period.
[13] Request for Extension, Attachments 3a and 3b.

However, it is unclear what prompted the Provider representative to make this request as the Request for Extension does not address this.[14] Interestingly, presumably in response to inquiry from the Provider representative, the Board's May 14, 2019 email resending the October 2, 2018 notice does confirm that "[t]his notification did identify the appealed period as FYE 12/31/2014."[15]

The Provider representative claims that "the Provider, through no fault of its own, did not have adequate knowledge of the due PPPP [*sic*] due date for CN 18-1851, FY14 until after the due date had passed."[16] Presumably, the Provider representative is claiming that he did not receive the notice of the May 10, 2019 PPP due date until May 14, 2019 when he requested a third copy of the October 2, 2018 notice. However, Board record is clear that the Board had sent the Provider representative two earlier copies of that notice (one on October 2, 2018 and another on January 8, 2019) and that Board Rules 2.2.2, 5.2, and 9 (including the Commentary as quoted above) are clear about the Provider representative responsibilities for managing its case and its duty to contact the Board if it does not timely receive a Letter of Acknowledgment and Critical Due Dates Notice for a newly-filed case. Indeed, the Provider representative's organization participates on OH CDMS[17] and had access to the OH CDMS case management system. As such, the Provider representative's organization had access to the docket for Case No. 18-1851, including the October 2, 2018 Letter of Acknowledgement and Critical Due Dates Notice for Case No. 18-1851. The above all suggests that the missed PPP filing was due to administrative error and/or mismanagement on the part of the Provider representative.[18]

Finally, the Board notes that the Request for Extension itself is flawed. First, it does not include the missing PPP.[19] Second, even if there was a valid reason for not filing the missing PPP concurrent with the Request for Extension, the Request for Extension fails to identify and explain it and also fails to explain how much time is needed for an extension.

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[14] The Board notes that the Board's May 14, 2019 email in Attachment 3a stating "Apologies for the oversite" was in response to the Provider representative's email at Attachment 3b stating that the Board's first May 14, 2019 email had "no attachment in the correspondence." *See* Request for Extension, Attachments 3a and 3b.

[15] Request for Extension, Attachment 3b.

[16] (Emphasis in original.)

[17] The Manager from the Provider representative's organization joined OH CDMS on August 20, 2018 and another member from the Provider representative's organization joined on November 9, 2018.

[18] In the same vein, the Board is perplexed why the Provider Representative states in the request for due date extension request that "[t]he reason why the PRRB on January 8, 2019 sent an email with an October 15, 2018 attachment with the May 24th due date is not clear to the Provider." As noted, it was the Provider representative's organization that requested the Board reissue the prior Board notifications. The Board recognizes that a manager at Strategic Reimbursement Group, LLC requested the Board reissuance while a vice president at Strategic Reimbursement Group requested the due date extension. *See supra* note 8. The fact that the vice president did not know what its manager had previously done in this case suggests that the late filing was more about administrative error and/or mismanagement of Case No. 18-1851 on the part of the Provider representative.

[19] The Provider received the third copy of the October 2, 2018 notice on May 14, 2019 but did not file the Request for Extension ***until 17 days later*** on May 31, 2019. It is unclear why the missing PPP was not included with the Request for Extension. *See* Board Rule 47.3.

Because the PPP was not received by the Board by the May 10, 2019 due date as required by the Board's October 2, 2018 Letter of Acknowledgement and Critical Due Dates Notice (reissued January 8, 2019) and by 42 C.F.R. § 405.1868, the Board finds that the Provider failed to timely file its PPP. Moreover, the Board finds that, pursuant to Board Rule 23.5, the Provider has not demonstrated good cause for the Request for Extension.[20] Accordingly, the Board hereby dismisses the appeal and closes Case No. 18-1851 pursuant to Board Rule 23.5 and 42 C.F.R. § 405.1868(b).

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

Board Members Participating:

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For the Board:

7/17/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[20] *See also* 42 C.F.R. § 405.1868(b)(2).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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James Ravindran
Quality Reimbursement Services
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RE: ***EJR Determination***

09-1890GC BHCS DSH 07 - Medicare Part C Days
14-1696GC St. Luke's Health System 2009 NPR Based Medicare Part C CIRP Group
14-3268GC QRS Providence 2006 SSI Fraction Part C Days CIRP Group
14-4405GC QRS John C. Lincoln HN 2009 Medicaid Fract./Medicare Mngd Care Part C Days CIRP
15-0752GC QRS John C. Lincoln HN 2010 Medicaid Fract./Medicare Mngd Care Part C Days CIRP
15-1625GC QRS John C. Lincoln HN 2011 Medicaid Fract. Medicare Mngd Care Pt. C Days CIRP
16-0387GC QRS SSEPR 2012 DSH Medicaid Fract. Medicare Mngd Care Part C Days CIRP Grp

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 26, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

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

[1] Providers' EJR request at 1.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] (Emphasis added.)
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

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[13] 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

[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.

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

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[15]

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

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

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

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."[19] In response to a comment regarding this change, the Secretary explained that:

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

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[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] 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.
[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[19] 69 Fed. Reg. at 49099.

> *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.[20]

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.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[22] 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."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] 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.[25] However, the Secretary has not acquiesced to that decision.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 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).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] 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*.[27] 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.[28] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007-2012.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-

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.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] Providers' EJR Request at 1.

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[30] 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.[31]

On August 21, 2008, new regulations governing the Board were effective.[32] 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*").[33] 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.[34]

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

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

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[30] 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.).
[31] *Bethesda*, 108 S. Ct. at 1258-59.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[33] 201 F. Supp. 3d 131 (D.D.C. 2016).
[34] *Id.* at 142.
[35] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] Although case numbers 14-1696GC and 15-1625GC were established as group appeals, they now only have a single participant and the Board is electing to treat the cases as individual appeals. The participants in case number 14-1696GC and 15-1625GC have met the $10,000 threshold for Board jurisdiction over individual appeals.[37] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2007-2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[38] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[39] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[40]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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[36] *See* 42 C.F.R. § 405.1837.
[37] *See* 42 C.F.R. § 405.1835.
[38] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[39] *See* 42 U.S.C. § 1395oo(f)(1).
[40] One of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

Board Members Participating:

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

FOR THE BOARD:

7/18/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Justin Lattimore, Novitas
Geoff Pike, First Coast Service Options, Inc.
John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Director, JH Provider Audit & Reimbursement
Novitas Solutions, Inc.
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Pittsburgh, PA 15219

RE: ***Jurisdictional Decision***
Covenant Health System - Lakeside
PRRB Case No.: 14-1115

Dear Mr. Olvera and Mr. Lattimore,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the record in the above-captioned appeal and determined that it does not have jurisdiction over two of the three issues now under appeal. The Board's decision is set forth below.

Pertinent Facts:

Covenant Medical Center - Lakeside (the "Provider") appealed an Original Notice of Program Reimbursement (NPR) dated June 7, 2013 for its fiscal year end (FYE) June 30, 2009 cost reporting period. On December 2, 2013, the Provider filed an individual appeal request which contained seven issues. The Provider withdrew one issue, and transferred three issues to group appeals. The remaining three issues in the appeal are:

1) Issue No. 1 addressing Disproportionate Share Hospital/Supplemental Security Income ("DSH/SSI") Percentage (Provider Specific) errors and preserving the future right to request realignment of the SSI Percentage to the Provider' fiscal year end,

2) Issue No. 2 addressing DSH/SSI Percentage (Provider Specific) errors in the SSI percentage due to failure to include all SSI entitled patients, and

3) Issue No. 4 addressing DSH Medicaid Eligible Days.

The Medicare Contractor filed a jurisdictional challenge on May 1, 2019, challenging both of the DSH/SSI Percentage (Provider Specific) issues, Issue Nos. 1 and 2, in the appeal.

Medicare Contractor's Position

The Medicare Contractor argues the potions of Issue No. 1 and 2 which claim problems with SSI data accuracy are duplicative of Issue No. 3, which has been transferred to Case No. 13-3931G. The Medicare Contractor states that the argument addressing the accuracy of the DSH/SSI Percentage is the same argument in all three issues as the Medicare Contractor is required to use the SSI Percentage provided by the Centers for Medicare & Medicaid.

Additionally, the Medicare Contractor contends the aspect of Issue No. 1 addressing the recalculation of the Provider's SSI Percentage using the Provider's cost reporting year should be dismissed as no final determination has been made regarding this issue. The Medicare Contractor asserts that realignment to the Provider's fiscal year end is a Provider election, and the Medicare Contractor does not make a final determination regarding this issue. Because the Medicare Contractor has not made a final determination regarding this issue, the Medicare Contractor claims the Provider does not have a right to a Board hearing on this issue under 42 C.F.R. § 405.1835.

The Medicare Contractor requests that the Board dismiss Issue Nos. 1 and 2 as they are duplicative of Issue No. 3 which has been transferred. The Medicare Contractor states that duplicative issues are prohibited, and the Board does not have jurisdiction over the issue of the Provider wanting to change its election of the fiscal year end for the SSI Percentage.

Provider's Position

Covenant Medical Center – Lakeside filed a Jurisdictional Response (May 31, 2019), and contends that both DSH/SSI Percentage (Provider Specific) issues are separate and distinct from Issue No. 3 addressing DSH/SSI Percentage (Systemic Errors). The Board notes that the Provider refers to only one DSH/SSI Percentage (Provider Specific) issue in its Jurisdictional Response, but there are two issues in the appeal with that same name.

The Provider states that Issue No. 3 addresses the various errors discussed in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20 (D.D.C. 2008) which result in the SSI data not reflecting all individuals who are eligible for SSI. The Provider states the DSH/SSI Percentage (Provider Specific) issue is different from the errors in the *Baystate* case because it involves various errors of omission and commission that do not fit in the systemic errors category. The Provider asserts the DSH/SSI Percentage (Provider Specific) issue is appealable because the Medicare Contractor made an adjustment to the SSI percentage and the Provider is dissatisfied with the amount of its DSH payment. The Provider requests that the Board find it has jurisdiction over the DSH/SSI Percentage (Provider Specific) issue.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. 42 U.S.C. §1395oo(a) provides, in relevant part:

> Any provider of services which has filed a required cost report within the time specified in the regulations may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . if –
>
> (1) such provider
>
> > (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by this report.

Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes, and there is no evidence in the record that such a request has been made.

DSH/SSI Percentage (Provider Specific) – Issue No. 1

The Board dismisses Issue No. 1 addressing the DSH SSI Percentage (Provider Specific) issue because it is duplicative of the DSH SSI Percentage (Systemic Errors) issue that was transferred to Case No. 13-3931G. A provider may not appeal an issue from a single final determination in more than one appeal pursuant to PRRB Rule 4.5 (2018).

The Issue No. 1 - DSH/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor ('MAC') used the correct Supplemental Security Income ('SSI") percentage in the Disproportionate Share Hospital ('DSH') calculation."[1] The Provider's legal basis for the Issue No. 1 - DSH/SSI Percentage (Provider Specific) issue is that "the MAC did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)." [2] The Provider contends that "it disagrees with the MAC's calculation of the computation of the DSH

[1] *Model Form A – Individual Appeal Request* (Nov. 29, 2013), Tab 3 – Appeal Issues at 1.
[2] *Id*.

percentage set for at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's regulations."[3] Issue No. 3, the DSH/SSI (Systemic Errors) issue is "[w]hether the Secretary properly calculated the Provider's Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI') percentage."[4] Both Issue No. 1 and Issue No. 3 discuss SSI entitled patients which were allegedly excluded from the DSH/SSI Percentage.[5] Therefore, the cost issue and supporting arguments supplied by the Provider for Issue No. 1 are duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was transferred to a group appeal.

Also pertaining to Issue No. 1 – DSH/SSI Percentage (Provider Specific), the Board dismisses the aspect of this issue preserving a right to request realignment of the Supplemental Security Income ("SSI") percentage from the federal fiscal year to its cost reporting period for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), to determine a Provider's DSH percentage, "if a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The Provider's right to request realignment is a provider election and is not an appealable issue.

DSH/SSI Percentage (Provider Specific) Issue – Issue No. 2

The Board also dismisses Issue No. 2 addressing the DSH/SSI Percentage (Provider Specific) issue from this case because it is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was transferred to Case No. 13-3931G. A provider may not appeal an issue from a single final determination in more than one appeal pursuant to PRRB Rule 4.5 (2018).

The Issue No. 2 - DSH/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor ('MAC') used the correct Supplemental Security Income ('SSI") percentage in the Disproportionate Share Hospital ('DSH') calculation."[6] The Provider's legal basis for the Issue No. 2 - DSH/SSI Percentage (Provider Specific) issue is that "the MAC did not determine Medicare DSH reimbursement in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] The Provider contends that "it disagrees with the MAC's calculation of the computation of the DSH percentage set for at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's regulations."[8] Issue No. 3, the DSH/SSI (Systemic Errors) issue is "[w]hether the Secretary properly calculated the Provider's Disproportionate Share Hospital ('DSH')/Supplemental Security Income ('SSI') percentage."[9] Both Issue No. 2 and Issue No. 3 discuss SSI entitled patients which were allegedly excluded from the DSH/SSI Percentage.[10] Therefore, the cost issue and supporting arguments supplied by the Provider for

[3] *Id*.
[4] *Id. at 2.*
[5] *Model Form A – Individual Appeal Request* (Nov. 29, 2013), Tab 3 – Appeal Issues at 1 and 3.
[6] *Model Form A – Individual Appeal Request* (Nov. 29, 2013), Tab 3 – Appeal Issues at 1.
[7] *Id*.
[8] *Id*.
[9] *Id. at 2.*
[10] *Model Form A – Individual Appeal Request* (Nov. 29, 2013), Tab 3 – Appeal Issues at 1 and 3.

Issue No. 2 are duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was transferred to a group appeal.

As stated above, Issue Nos. 1 and 2 are dismissed from this appeal. The case remains open for resolution of the last remaining issue – Issue No. 4 addressing DSH Medicaid Eligible Days.

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

Board Members

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

FOR THE BOARD

7/18/2019

X Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member
Signed by: Gregory H. Ziegler -S

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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

RE: QRS MultiCare 2013 Two Midnight Census IPPS Payment Reduction CIRP Group
Case No. 16-1993GC

Dear Mr. Ravindran,

The Providers' Group Appeal Request was received by the Provider Reimbursement Review Board ("Board") on July 11, 2016 and each of the providers appealed via a Notice of Program Reimbursement ("NPR"). On February 6, 2019, as required by 42 C.F.R. § 405.1842(c), the Provider Reimbursement Review Board ("Board") notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate. Providers notified the Board that the group was fully formed on March 6, 2019 and subsequently submitted the Final Schedule of Providers. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal question:

> Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014-2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of CMS. [1]

In their comments, the Providers have stated that the Board is required to comply with all provisions of the Social Security Act and regulations issued thereunder. As a result, the Board does not have the authority to declare the 0.02 percentage decrease in IPPS rates invalid or decide that the final rule at issue is procedurally invalid, arbitrary, capricious, and outside the statutory authority of CMS.[2] The Medicare Contractor asserts that it is premature to consider whether EJR is appropriate because it is not clear what relief is being sought. They point out that, in 2017, a 0.6 percent increase to the IPPS rate was implemented to remedy the 0.2 percent decreases from FYs 2014-2016. They argue that the remedy implemented in 2017 has ameliorated the underpayments alleged to have occurred in FY 2014, and that the Board should demand a higher level of clarity from the Providers before considering whether to grant EJR.[3]

The relevant statutory provisions and regulations for this issue are set forth below.

[1] *See* Provider's Group Appeal Request, Tab 2 (July 11, 2016).
[2] Provider's Comments on Board's Proposed EJR, 2 (Apr. 8, 2019).
[3] MAC's Comments on Board's Proposed EJR, 3-4 (Mar. 8, 2019).

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014,[4] the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year Outpatient PPS ("OPPS") rule[5] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.[6] It was observed that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had risen from approximately 3 percent in 2006 to 8 percent in 2011.[7] This raised a concern about the financial impact on Medicare beneficiaries who may pay more for the same services as outpatients than they would if they were admitted to the hospital as inpatients.[8]

The Secretary noted that the trend toward outpatient status with extended observation services may have been attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied by the Medicare review contractor. Such claims were denied when the contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS had been advised by stakeholders that the hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review. They were doing this by treating beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. [9]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary.[10]

The Secretary also reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. At the time, the Medicare Benefit Policy Manual stated that, once the reason for the observation care is resolved, the typical decision to admit a beneficiary as an inpatient can usually be made within 24 hours, and most within 48 hours. It also stated that an overnight stay may be a factor in the admission decision. Physicians were to use the 24-hour or overnight period as a benchmark, that is, patients who were expected to need care for 24 hours or overnight should have been admitted as inpatients. Generally, a beneficiary was considered an inpatient if formally admitted with the expectation that he or she would remain in the hospital overnight, regardless of whether there was a later transfer or discharge resulting in no overnight patient stay. It explained that only rare and exceptional

[4] 78 Fed. Reg. 50495 (Aug. 19, 2013).
[5] 77 Fed. Reg. 45061, 45155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68210, 68426-33 (Nov. 15, 2012).
[6] 78 Fed. Reg. at 50906.
[7] *Id.* at 50907.
[8] *Id.*
[9] *Id.*
[10] *Id.*

cases require reasonable and necessary observation services which span more than 48 hours. Length of stay, however, is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[11]

In the FFY 2014 IPPS proposed rule,[12] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment. This became known as the "2-Midnight Rule." Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[13]

The 2-Midnight Rule

In the final 2014 IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule adopted the 2-Midnight Rule, providing instructions that gave a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designated services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided.[15]

The Secretary's actuaries estimated that the 2-Midnight Rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters to inpatient.[16] This additional expenditure would be partially offset by reduced expenditures

[11] *See* 78 Fed. Reg. at 50907-08 (*citing* Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 6, § 20.6 & Ch. 1, § 10).
[12] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[13] 78 Fed. Reg. at 50908.
[14] 78 Fed. Reg. at 50944.
[15] *Id.*
[16] *Id.* at 50952.

from the shift of shorter stay inpatient encounters to outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters.[17]

In light of the impact of the 2-Midnight Rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-Midnight Rule. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

In the proposed 2016 OPPS rule, the Secretary noted that the data was, at that point, consistent with the assumptions used to develop the 0.2 percent adjustment estimate. Long outpatient stays and very short inpatient stays were declining, while 2-4 day inpatient stays increased.[20] As time went on, however, the impact of the shift between inpatient and outpatient encounters proved to be more complex than anticipated, and in the proposed 2017 IPPS rule, the Secretary proposed removing the reduction beginning in FY 2017.[21] The Secretary also proposed a one-time prospective increase of 0.6 percent in FY 2017 to address the effect of the 0.2 percent reductions in FYs 2014, 2015, and 2016.[22] The 0.2 percent reduction was removed indefinitely, and the one-time increase of 0.6 percent was adopted for FY 2017 in the final IPPS rule for 2017.[23] In the final IPPS rule for 2018, the one-time 0.6 percent increase was removed for FY 2018.[24]

Decision of the Board

The Board has reviewed the Providers' Group Appeal Request and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Providers timely appealed from Notices of Program Reimbursement and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal.[25]

The Medicare Contractor suggests the one-time payment increase in FY 2017 may have decreased the amount in controversy to an amount less than the jurisdictional minimum. The amount in controversy

[17] *Id.* at 50952-53.
[18] *Id*.
[19] *Id.* at 50990.
[20] 80 Fed. Reg. 39199, 39370 (July 8, 2015).
[21] 81 Fed. Reg. 24945, 25140 (Apr. 27, 2016).
[22] *Id.*
[23] 81 Fed Reg. 56761, 57059 (Aug. 22, 2016).
[24] 82 Fed. Reg. 37990, 38287-88 (Aug. 14, 2017).
[25] *See* 42 C.F.R. § 405.1837(a).

requirement set forth in 42 U.S.C. § 1395oo(a)(2). However, this is nothing more than a jurisdictional provision, and no extensive fact-finding is necessary to determine that it exceeds the jurisdictional threshold.[26] Indeed, the amount in controversy is normally determined from the face of the pleadings.[27] Federal courts have found the amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2) to be comparable to the amount in controversy provision applicable to diversity cases under 28 U.S.C. § 1332, for which the Supreme Court has held that the sum claimed by the plaintiff controls if the claim is apparently made in good faith.[28] The Board finds that the amounts claimed by the Providers was made in good faith and, consequently, the Board has determined that it has jurisdiction over the appeal. The Board notes that each of the providers in the group appealed from the NPR for their fiscal year ending December 31, 2013 and that, per the amount in controversy calculation, only that portion of the fiscal year from October 1, 2013 to December 31, 2013 is at issue in this appeal.[29]

This issue involves a challenge to the validity of a provision found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.2 percent adjustment to IPPS, as set forth in the FY 2014 IPPS final rule, is appropriate and that, therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

1) It has jurisdiction over the matter for the subject year[30] and the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the 0.2 percent reduction to the standardized amount, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Secretary's 0.2 percent reduction to the standardized amount, the hospital specific rate for the issue, as set forth in the FY 2014 IPPS final rule, is valid.

Accordingly, the Board finds that the 0.2 percent reduction issue for FY 2014 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year.[31] The Providers have 60 days from the receipt of this decision to

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[26] *Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 56 (D.D.C. 2010).
[27] *Beacon Healthcare Servs., Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010).
[28] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, 3 (N.D. Okla. 2010). *See also Russell-Murray Hospice, Inc.*, 724 F. Supp. 2d at 56 ("To require the PRRB to gather data and perform a detailed calculation of the specific amount in controversy simply to establish its jurisdiction to hear an appeal would represent a significant departure from the established scope of jurisdictional fact-finding . . .").
[29] This is consistent with the fact that the FY 2014 IPPS final rule was effective beginning October 1, 2013 for FFY 2014.
[30] *See supra* note 29 and accompanying text.
[31] *See supra* note 29 and accompanying text.

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

Board Members Participating:

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

For the Board:

7/18/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
John Bloom, Noridian Healthcare Solutions (J-F)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Bartow Regional Medical Center (Provider No. 10-0121)
FYE 03/31/2014
Case No.:17-0382

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 17-0382. The decision of the Board is set forth below.

Background:

The Provider has appealed a Notice of Program Reimbursement ("NPR") for FYE 03/31/2014. The Provider appealed 11 issues. The Provider submitted its Preliminary Position Paper and indicated that it planned to transfer all issues to various group appeals except for two issues, namely the SSI Provider Specific and Medicaid Eligible Days. The Medicaid Contractor submitted a jurisdictional challenge on April 19, 2018 and the Board received the Provider's response to the challenge on May 22, 2018.

Medicare Contractor Contentions:

SSI Part A Realignment

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue. The Medicare Contractor contends that the issue is suitable for reopening and not an appealable issue, but adds that with respect to a SSI realignment request, that it has not made a final determination with which a Provider can be satisfied, therefore the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835.

Medicaid Managed Care Part C Days and Dual Eligible Days

The Medicare Contractor argues that the Provider has already bifurcated the Medicare Managed Care Part C Days issue into two distinct issues, Medicare Managed Care Part C Days within the SSI Fraction and Medicare Managed Care Part C days within the Medicaid Fraction and concludes that these fractions are

added up and expressed as the DSH percentage and, consequently, are redundant. [1] Similarly, the Medicare Contractor argues that the Provider has already bifurcated the Dual Eligible Days issue into two separate distinct issues, Dual Eligible within the SSI Fraction and Dual Eligible days within the Medicaid Fraction and similarly concludes that these fractions added up and expressed as the DSH percentage are redundant.

Duplicate Issues – SSI Provider Specific & SSI Systemic Errors Issue

The Provider is appealing the SSI percentage under separate issues. The Medicare Contractor asserts that the both issues refer to the same Audit Adjustment Nos. 5, 15, 18, S-D and that the SSI data is the underlying issue for both DSH and SSI Provider Specific issues.

Uncompensated Care – UCC

The Medicare Contractor challenged jurisdiction over this issue; however, the UCC issue was transferred to group appeal on June 15, 2017 (Case No. 17-0573GC) and that group appeal was subsequently closed as of December 11, 2018.

Provider Contentions:

SSI Provider Specific

The Provider contends that the Medicare Contractor is incorrect in arguing that that the DSH/SSI realignment issue is not an appealable issue. The Provider is addressing the realignment issue of the SSI percentage and also various issues of omission and commission that do not fit into the "systematic errors" category. Therefore, the Provider contends that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and is dissatisfied with the amount of DSH payments that it received for fiscal year end as a result of its understated percentage.

Duplicate SSI Issues

The Provider contends that each of the appealed SSI issues are separate, distinct issues and represent different components of the SSI issue that was adjusted during the audit.

Medicare Managed Care Part C Days & Dual Eligible Days Duplicate Issues

The Provider agrees that there are duplicate issues and requests that the Medicaid Fraction/Medicare Managed Care Part C Days issue be consolidated with Medicare Managed Care Part C Days issue. The Provider also requests that the Medicaid Fraction/Dual Eligible Days issue be consolidated with the Dual Eligible Days issue.

Board Decision:

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

[1] *See* Medicare Contractor's Jurisdictional Challenge at 4.

SSI Provider Specific

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: (1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; and (2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that the Provider transferred to Case No. 17-0578GC and is hereby dismissed by the Board.[2] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[3] The Provider's legal basis for its SSI Provider Specific issue also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[4] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and it ". . . specifically disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[5]

The Provider's Systemic Errors issue is "Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage." Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred into a group appeal.

CMS regulation interpretation is clearly not specific to only this provider, it applies to ***all*** SSI calculations and, as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal. The Provider is misplaced in trying to state that the regulatory challenge is related to any "provider specific" SSI issue that could possibly remain in an individual appeal.

Because the Systemic Errors issue was transferred to a group, the Board hereby dismisses this aspect of the SSI Provider Specific issue.

The second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is hereby dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. Accordingly, the Board hereby dismisses this remaining aspect of the Provider Specific issue.

[2] *See* Provider's Individual Appeal Request at Tab 3.
[3] *Id.* at Tab 3, Issue 1.
[4] *Id.*
[5] *Id.*

Medicare Part C and Dual Eligible Days Duplicate Issues

The Board finds that the Medicaid Fraction/Medicare Managed Care Days and the Medicare Managed Care Days issue are duplicative and is hereby consolidated into the Medicare Managed Care Days issue already in group appeal Case No. 17-0576GC.

Similarly, the Board finds that the Medicaid Fraction/Dual Eligible Days issue and the Dual Eligible Days issue are duplicative. Therefore, the Medicaid Fraction/Dual Eligible Days issue are hereby consolidated into Dual Eligible Days issue, which has been transferred to a group appeal, Case No. 17-0577GC, QRS HMA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group.

Conclusion:

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue.

The Board finds that the Medicaid Fraction/Medicare Managed Care Days issue and the Medicare Managed Care Days issue are duplicative. These issues are hereby consolidated into the Medicare Managed Care Days issue already in group appeal Case No. 17-0576GC.

Similarly, the Board finds that the Medicaid Fraction/Dual Eligible Days issue and the Dual Eligible Days issue are duplicative. Therefore, the Medicaid Fraction/Dual Eligible Days issue is hereby consolidated into Dual Eligible Days issue, which has been transferred to a group appeal, Case No. 17-0577GC, QRS HMA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group.

The UCC Distribution Pool issue was transferred to a group appeal on June 15, 2017 (Case No. 17-0573GC) and subsequently closed as of December 11, 2018.

The Medicaid Eligible days issue remains pending in the appeal.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

7/18/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

J.C. Ravindran and Russel Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Suite 570A
Arcadia, CA 91006

RE: QRS FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group Appeals
Cases Nos.: 17-0655GC, *et al*. (*See* Attached Listing of Appeals)

Dear Mr. Ravindran & Mr. Kramer,

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals each of which were formed based on appeals of the FY 2017 inpatient prospective payment system ("IPPS") final rule published on August 22, 2016.[1] On February 6, 2019, as required by 42 C.F.R. § 405.1842(c), the Board notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. Providers notified the Board that the groups were fully formed on March 6, 2019 and subsequently submitted the Final Schedule of Providers. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal question:

> Whether the .06 positive adjustment for the FY 2017 Inpatient Prospective Payment System ("IPPS") final rule is invalid for being arbitrary and capricious and promulgated in a procedurally deficient way.[2]

In their comments, the Providers have stated that the Board is required to comply with all provisions of the Social Security Act and regulations issued thereunder. As a result, the Board does not have the authority to declare the 0.2 percentage decrease in IPPS rates invalid or decide that the final rule at issue is procedurally invalid, arbitrary, capricious, and outside the statutory authority of CMS.[3]

The Medicare Contractor asserts that it is premature to consider whether EJR is appropriate. They point out that their jurisdictional challenge is over two years old, and that there has been enough time to determine whether there was, in fact, a negative financial impact on each hospital due to the 2-Midnight Rule. The Medicare Contractor argues that each hospital should be required to calculate a more accurate amount in controversy, which may reveal that there was no negative impact by the rule and therefore no justiciable controversy. Furthermore, they assert that some of the providers in these group appeals may have been plaintiffs in the ongoing *Shands* litigation, in which the Secretary was granted summary judgment. The Medicare Contractor insists that the Providers should clarify whether this is the case before the Board grants EJR.[4]

[1] 81 Fed. Reg. 56762 (Aug. 22, 2016).
[2] *See* Providers' Response to MAC's Thirty-Day Letter (Feb. 8, 2017) (17-0655GC).
[3] Provider's Comments on Board's Proposed EJR, 2 (Mar. 22, 2019).
[4] MAC's Comments on Board's Proposed EJR, 3-4 (Mar. 8, 2019).

The relevant statutory provisions and regulations for this issue are set forth below.

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014,[5] the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year Outpatient PPS ("OPPS") rule[6] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.[7] It was observed that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had risen from approximately 3 percent in 2006 to 8 percent in 2011.[8] This raised a concern about the financial impact on Medicare beneficiaries who may pay more for the same services as outpatients than they would if they were admitted to the hospital as inpatients.[9]

The Secretary noted that the trend toward outpatient status with extended observation services may have been attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied by the Medicare review contractor. Such claims were denied when the contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS had been advised by stakeholders that the hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review. They were doing this by treating beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. [10]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary.[11]

The Secretary also reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. At the time, the Medicare Benefit Policy Manual stated that, once the reason for the observation care is resolved, the typical decision to admit a beneficiary as an inpatient can usually be made within 24 hours, and most within 48 hours. It also stated that an overnight stay may be a factor in the admission decision. Physicians were to use the 24-hour or overnight period as a benchmark, that is, patients who were expected to need care for 24 hours or overnight should have been admitted as inpatients. Generally, a beneficiary was considered an inpatient if formally admitted with the

[5] 78 Fed. Reg. 50,495 (Aug. 19, 2013).
[6] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68,210, 68,426-33 (Nov. 15, 2012).
[7] 78 Fed. Reg. at 50,906.
[8] *Id.* at 50,907.
[9] *Id.*
[10] *Id.*
[11] *Id.*

expectation that he or she would remain in the hospital overnight, regardless of whether there was a later transfer or discharge resulting in no overnight patient stay. It explained that only rare and exceptional cases require reasonable and necessary observation services which span more than 48 hours. Length of stay, however, is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[12]

In the FFY 2014 IPPS proposed rule,[13] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment. This became known as the "2-Midnight Rule." Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[14]

The 2-Midnight Rule

In the final 2014 IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule adopted the 2-Midnight Rule, providing instructions that gave a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[15]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designated services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided.[16]

The Secretary's actuaries estimated that the 2-Midnight Rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000

[12] *See* 78 Fed. Reg. at 50,907-08 (*citing* Medicare Benefit Policy Manual, CMS Pub. 100-02, Ch. 6, § 20.6 & Ch. 1, § 10).
[13] *See generally* 78 Fed. Reg. 27,486 (May 10, 2013).
[14] 78 Fed. Reg. at 50,908.
[15] 78 Fed. Reg. at 50,944.
[16] *Id.*

encounters to inpatient.[17] This additional expenditure would be partially offset by reduced expenditures from the shift of shorter stay inpatient encounters to outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters.[18]

In light of the impact of the 2-Midnight Rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-Midnight Rule. Consequently, the standardized amount was reduced by 0.2 percent.[19] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[20]

In the proposed 2016 OPPS rule, the Secretary noted that the data was, at that point, consistent with the assumptions used to develop the 0.2 percent adjustment estimate. Long outpatient stays and very short inpatient stays were declining, while 2-4 day inpatient stays increased.[21] As time went on, however, the impact of the shift between inpatient and outpatient encounters proved to be more complex than anticipated, and in the proposed 2017 IPPS rule, the Secretary proposed removing the reduction beginning in FY 2017.[22] The Secretary also proposed a one-time prospective increase of 0.6 percent in FY 2017 to address the effect of the 0.2 percent reductions in FYs 2014, 2015, and 2016.[23] The 0.2 percent reduction was removed indefinitely, and the one-time increase of 0.6 percent was adopted for FY 2017 in the final IPPS rule for 2017.[24] In the final IPPS rule for 2018, the one-time 0.6 percent increase was removed for FY 2018.[25]

Decision of the Board

The Board has reviewed the Providers' Group Appeal Requests and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a). With respect to jurisdiction, the Board concludes that the Providers timely

[17] *Id.* at 50,952.
[18] *Id.* at 50,952-53.
[19] *Id*.
[20] *Id.* at 50,990.
[21] 80 Fed. Reg. 39,199, 39,370 (July 8, 2015).
[22] 81 Fed. Reg. 24,945, 25,140 (April 27, 2016).
[23] *Id.*
[24] 81 Fed Reg. 56,761, 57,059 (Aug. 22, 2016).
[25] 82 Fed. Reg. 37,990, 38,287-88 (Aug. 14, 2017).

appealed from the Federal Register published on August 22, 2016, [26] and the amount in controversy exceeds the $50,000 threshold necessary for a group appeal in each case.[27]

The Medicare Contractor suggests that the one-time payment increase in FY 2017 may have decreased the amount in controversy to an amount less than the jurisdictional minimum. The amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2). However, this is nothing more than a jurisdictional provision, and no extensive fact-finding is necessary to determine that it exceeds the jurisdictional threshold.[28] Indeed, the amount in controversy is normally determined from the face of the pleadings.[29] Federal courts have found the amount in controversy requirement set forth in 42 U.S.C. § 1395oo(a)(2) to be comparable to the amount in controversy provision applicable to diversity cases under 28 U.S.C. § 1332, for which the Supreme Court has held that the sum claimed by the plaintiff controls if the claim is apparently made in good faith.[30] The Board finds that the amounts claimed by the Providers was made in good faith and, consequently, the Board has determined that it has jurisdiction over the appeal. Consequently, the Board has determined that it has jurisdiction over the appeal.

This issue involves a challenge to the validity of a provision found in the proposed and final rules published in the Federal Register impacting FY 2017. Further, the Board finds that it lacks the authority to decide the legal question of whether the 0.6 percent positive adjustment to IPPS for FY 2017 adopted and explained in the final rule at 81 Fed. Reg. 56762, 57058-57060 (Aug. 22, 2016) is appropriate and that, therefore, EJR is appropriate for the issue under dispute in this case.

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the 0.6 percent positive adjustment to the standardized amount for FY 2017, there are no findings of fact for resolution by the Board;

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

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[26] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is not necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await Notices of Program Reimbursement (NPRs) prior to filing a PRRB appeal"); *District of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[27] *See* 42 C.F.R. § 405.1837(a).
[28] *Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 56 (D.D.C. 2010).
[29] *Beacon Healthcare Services, Inc. v. Leavitt*, 629 F.3d 981, 984 (9th Cir. 2010).
[30] *See Infinity Care of Tulsa v. Sebelius*, 2011 WL 778111, 3 (N.D. OK 2010). *See also Russell-Murray Hospice, Inc.*, 724 F. Supp. 2d at 56 ("To require the PRRB to gather data and perform a detailed calculation of the specific amount in controversy simply to establish its jurisdiction to hear an appeal would represent a significant departure from the established scope of jurisdictional fact-finding . . .").

4) It is without the authority to decide the legal question of whether the Secretary's 0.6 percent positive adjustment to the standardized amount for FY 2017 as adopted and explained in the final rule at 81 Fed. Reg. 56762, 57058-57060 (Aug. 22, 2016) is valid.

Accordingly, the Board finds that the 0.6 positive adjustment issue properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

7/18/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lauri Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)
John Bloom, Noridian Healthcare Solutions (J-F)
Bill Tisdale, Novitas Solutions, Inc. (J-H)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Pam VanArsdale, National Government Services, Inc. (J-K)

Listing of Appeals
QRS FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group Appeals

17-0655GC	QRS Asante Health FFY 2017 Two Midnight Census IPPS Payment Reduction Group
17-0796GC	QRS WCHN FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-0847GC	QRS MultiCare FFY2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-0911GC	QRS Health First FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-0934GC	QRS Carolinas Hlth FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-0940GC	QRS Avera Health FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-0948GC	QRS Novant Hlth FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-1156GC	QRS BSWH FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group
17-1157GC	QRS HHC FFY 2017 Two Midnight Census IPPS Payment Reduction CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Avenue, Suite 200
Washington, DC 20006-2706

RE: King & Spalding FFY 2018 Two-Midnight IPPS Rate CIRP Group Cases
Cases Nos.: 18-0055GC, *et al*. (See Attached Listing of Appeals)

Dear Mr. Polston,

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals each of which were formed based on appeals of the FFY 2018 inpatient prospective payment system ("IPPS") final rule published on August 14, 2017.[1] On January 15, 2019, as required by 42 C.F.R. § 405.1842(c), the Board notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced CIRP group cases. Providers notified the Board that the groups were fully formed on February 14, 2019 and subsequently submitted the Final Schedules of Providers. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal question:

> Whether the Secretary acted arbitrarily, capriciously and violated the Administrative Procedure Act by failing to adopt a permanent and positive adjustment to federal fiscal year ("FFY") 2018 Inpatient Prospective Payment System ("IPPS") rates, 82 Fed. Reg. 27990 (Aug. 14, 2017), to offset the aggregate decline in IPPS payments resulting from the Two-Midnight inpatient coverage rule.

With regard to the proposed EJR, the Providers simply state that the Board has granted EJR with respect to this issue in the past and that they have no objection to the Board doing so here.[2] In their comments, the Medicare Contractor states that the Board has subject matter jurisdiction, that there are no findings of fact to be made by the Board, that the Board is bound by existing Medicare law and regulation, and that the Board lacks the authority to increase the standardized IPPS rates for FFY 2018 as requested by the Providers. As a result, the Medicare Contractors agree that this issue is appropriate for EJR.[3]

The relevant statutory provisions and regulations for this issue are set forth below.

[1] 82 Fed. Reg. 37990 (Aug. 14, 2017).
[2] Provider's Comments on Board's Proposed EJR, 2 (Apr. 10, 2019).
[3] MAC's Comments on Board's Proposed EJR, 3-4 (Feb. 14, 2019).

Statutory and Regulatory Background

In the final IPPS rule for FFY 2014,[4] the Secretary of Health and Human Services ("Secretary") indicated that she had expressed concern in the proposed calendar year Outpatient PPS ("OPPS") rule[5] about the length of time Medicare beneficiaries were spending as hospital outpatients receiving observation services.[6] It was observed that the number of cases of Medicare beneficiaries receiving observation services for more than 48 hours had risen from approximately 3 percent in 2006 to 8 percent in 2011.[7] This raised a concern about the financial impact on Medicare beneficiaries who may pay more for the same services as outpatients than they would if they were admitted to the hospital as inpatients.[8]

The Secretary noted that the trend toward outpatient status with extended observation services may have been attributable, in part, to hospitals' concerns about their ability to receive payment from Medicare under Part B when a Part A hospital inpatient claim is denied by the Medicare review contractor. Such claims were denied when the contractor determined the inpatient admission was not reasonable and necessary under 42 U.S.C. § 1395y(a)(1)(A). CMS had been advised by stakeholders that the hospitals appeared to be responding to the financial risk of admitting Medicare beneficiaries for inpatient stays that may later be denied upon contractor review. They were doing this by treating beneficiaries as outpatients receiving observation services for long periods of time, rather than admitting them as inpatients. [9]

In response to this concern, the Secretary proposed clarifications and changes regarding hospital payment under both Part A and Part B. The Secretary proposed to revise the Part B inpatient payment policy to allow payment under Part B for all reasonable and necessary hospital services furnished if the beneficiary had been treated as a hospital outpatient, rather than admitted as an inpatient. This policy would apply when a Medicare Part A hospital inpatient claim was denied or when a hospital determines after a discharge that the inpatient visit was not reasonable and necessary.[10]

The Secretary also reviewed hospital inpatient status criteria to improve CMS' policies governing when a Medicare beneficiary should be admitted as an inpatient and how hospitals should be paid for associated costs. At the time, the Medicare Benefit Policy Manual stated that, once the reason for the observation care is resolved, the typical decision to admit a beneficiary as an inpatient can usually be made within 24 hours, and most within 48 hours. It also stated that an overnight stay may be a factor in the admission decision. Physicians were to use the 24-hour or overnight period as a benchmark, that is, patients who were expected to need care for 24 hours or overnight should have been admitted as inpatients. Generally, a beneficiary was considered an inpatient if formally admitted with the expectation that he or she would remain in the hospital overnight, regardless of whether there was a later transfer or discharge resulting in no overnight patient stay. It explained that only rare and exceptional

[4] 78 Fed. Reg. 50495 (Aug. 19, 2013).
[5] 77 Fed. Reg. 45,061, 45,155-57 (July 30, 2012) and the final rule with comment period, 77 Fed. Reg. 68210, 68426-33 (Nov. 15, 2012).
[6] 78 Fed. Reg. at 50906.
[7] *Id.* at 50907.
[8] *Id.*
[9] *Id.*
[10] *Id.*

cases require reasonable and necessary observation services which span more than 48 hours. Length of stay, however, is not the sole basis for payment; it is the physician responsible for patient care who determines if the patient should be admitted.[11]

In the FFY 2014 IPPS proposed rule,[12] the Secretary proposed a new benchmark for purposes of medical review of hospital inpatient admissions (Medicare Part A payment). Under this proposal, beneficiaries who were expected to remain in the hospital to receive medically necessary care surpassing 2-midnights after the initiation of care would generally be appropriate for inpatient admission and inpatient payment. This became known as the "2-Midnight Rule." Medicare contractors were to consider all the time after the initiation of care at the hospital in applying the benchmark that inpatient admissions are generally reasonable and necessary (as long as a hospital was not prolonging the provision of care to surpass the 2-midnight timeframe).[13]

The 2-Midnight Rule

In the final 2014 IPPS rule, the Secretary pointed out that CMS had established policy that recognized there were certain situations in which an inpatient hospital admission was rarely appropriate. This IPPS rule adopted the 2-Midnight Rule, providing instructions that gave a benchmark to ensure that all beneficiaries receive consistent application of their Part A benefits to whatever clinical services were medically necessary.[14]

Due to persistently large, improper payment rates for short-stay hospital inpatient claims, and, in response to requests to provide additional guidance regarding proper billing of those services, the Secretary proposed to modify and clarify 42 C.F.R. § 412.3(c)(1). This regulation designated services that are inpatient only (without regard to duration of care), such as surgical procedures, diagnostic tests and other treatments that would be appropriate for inpatient admission and inpatient payment under Medicare Part A when the physician expects a stay that crosses 2 midnights and admits the beneficiary based on that expectation. The starting point for this 2-midnight instruction would be when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional services would be provided.[15]

The Secretary's actuaries estimated that the 2-Midnight Rule would increase IPPS expenditures by approximately $220 million. These additional expenditures would result from an expected net increase in hospital inpatient encounters due to some encounters spanning more than 2 midnights moving from OPPS to IPPS and some encounters of less than 2 midnights moving from IPPS to OPPS. The actuaries estimated that approximately 400,000 encounters would shift from outpatient to inpatient and approximately 360,000 encounters would shift from inpatient to outpatient, causing a net shift of 40,000 encounters to inpatient.[16] This additional expenditure would be partially offset by reduced expenditures

[11] *See* 78 Fed. Reg. at 50907-08 (*citing* The Medicare Benefit Policy Manual, CMS Pub. 100-02, Chapter 6, § 20.6 & Chapter 1, § 10).
[12] *See generally* 78 Fed. Reg. 27486 (May 10, 2013).
[13] 78 Fed. Reg. at 50908.
[14] 78 Fed. Reg. at 50944.
[15] *Id.*
[16] *Id.* at 50952.

from the shift of shorter stay inpatient encounters to outpatient encounters. The actuaries estimated that, on average, the per encounter payments for these outpatient encounters would be approximately 30 percent of the per encounter payments for the inpatient encounters.[17]

In light of the impact of the 2-Midnight Rule on IPPS and the systematic nature of the issue of inpatient status and improper payments under Medicare Part A for short-stay inpatient hospital claims, the Secretary decided it was appropriate to use her exceptions and adjustments authority under 42 U.S.C. § 1395ww(d)(5)(I)(i) to offset the $220 million in additional IPPS expenditures associated with the 2-Midnight Rule. Consequently, the standardized amount was reduced by 0.2 percent.[18] The Secretary made the same 0.2 percent reduction to capital IPPS rates as a result of the expenditures that were projected to result from the Secretary's policy on admission and medical review criteria for hospital inpatient services under Medicare Part A.[19]

In the proposed 2016 OPPS rule, the Secretary noted that the data was, at that point, consistent with the assumptions used to develop the 0.2 percent adjustment estimate. Long outpatient stays and very short inpatient stays were declining, while 2-4 day inpatient stays increased.[20] As time went on, however, the impact of the shift between inpatient and outpatient encounters proved to be more complex than anticipated, and in the proposed 2017 IPPS rule, the Secretary proposed removing the reduction beginning in FY 2017.[21] The Secretary also proposed a one-time prospective increase of 0.6 percent in FY 2017 to address the effect of the 0.2 percent reductions in FYs 2014, 2015, and 2016.[22] The 0.2 percent reduction was removed indefinitely, and the one-time increase of 0.6 percent was adopted for FY 2017 in the final IPPS rule for 2017.[23] In the final IPPS rule for 2018, the one-time 0.6 percent increase was removed for FY 2018.[24]

Decision of the Board

The Board has reviewed the Providers' Group Appeal Requests and the parties' comments regarding the proposed own motion EJR determination. The regulation, 42 C.F.R. § 405.1842(c), permits the Board to consider on its own motion whether it lacks the authority to decide a legal question relevant to the matter at issue once it has made a finding that it has jurisdiction to conduct a hearing under the provisions of 42 C.F.R. § 405.1840(a).

With respect to jurisdiction, the Board concludes that the Providers timely appealed from the Federal Register published on August 14, 2017,[25] and the amount in controversy exceeds the $50,000 threshold

[17] *Id.* at 50952-53.
[18] *Id*.
[19] *Id.* at 50,990.
[20] 80 Fed. Reg. 39199, 39370 (July 8, 2015).
[21] 81 Fed. Reg. 24945, 25140 (April 27, 2016).
[22] *Id*.
[23] 81 Fed Reg. 56761, 57059 (Aug. 22, 2016).
[24] 82 Fed. Reg. 37990, 38287-88 (Aug. 14, 2017).
[25] *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is not necessary in order for the Secretary to make PPS payments, and the appeals provisions applicable to PPS recipients cannot be read to require hospitals to file cost reports and await Notices of Program Reimbursement (NPRs) prior to filing a PRRB appeal"); *District*

necessary for a group appeal.[26] Consequently, the Board has determined that it has jurisdiction over the appeal.

This issue involves a challenge to the validity of a provision found in the proposed and final rules published in the Federal Register. Further, the Board finds that it lacks the authority to decide the legal question of whether the Secretary acted arbitrarily, capriciously and violated the Administrative Procedure Act by failing to adopt, as part of the FFY 2018 IPPS final rule, a permanent and positive adjustment to FFY 2018 IPPS rates to offset the aggregate decline in IPPS payments resulting from the Two-Midnight inpatient coverage rule.

The Board finds that:

1) It has jurisdiction over the matter for the subject year and the Providers are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding the failure to adopt a positive adjustment to the standardized amount, 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 whether the Secretary acted arbitrarily, capriciously and violated the Administrative Procedure Act by failing to adopt, as part of the FFY 2018 IPPS final rule, a permanent and positive adjustment to FFY 2018 IPPS rates to offset the aggregate decline in IPPS payments resulting from the Two-Midnight inpatient coverage rule.

Accordingly, the Board finds that the IPPS positive adjustment issue for FFY 2018 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants expedited judicial review on its own motion for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the cases.

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

7/18/2019

X Clayton J. Nix

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

of Columbia Hosp. Ass'n Wage Index Group Appeal, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).
[26] *See* 42 C.F.R. § 405.1837(a).

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Danene Hartley, National Government Services, Inc. (J-6)
Byron Lamprecht, WPS Government Health Administrators (J-5)

Listing of Appeals
King & Spalding FFY 2018 Two-Midnight IPPS Rate CIRP Group Cases.

18-0055GC	Piedmont Healthcare FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0067GC	Carilion Clinic FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0082GC	Cleveland Clinic FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0128GC	Intermountain Healthcare FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0155GC	Texas Health Partners FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0163GC	Houston Healthcare FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0248GC	Adventist Health System FFY 2018 Two Midnight IPPS Rate CIRP Group
18-0261GC	The University of Vermont Health Network FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0264GC	Fairview Health Services FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0288GC	Temple University Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0420GC	Mercy Health (Formerly Catholic Health Partners) FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0534GC	HealthPartners FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0539GC	Baptist Health Care FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0540GC	Houston Methodist FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0563GC	University of Virginia Health System FFY 2018 Two Midnight IPPS Rate CIRP Group
18-0564GC	OSF Healthcare FFY 2018 Two Midnight IPPS Rate CIRP Group
18-0601GC	Bon Secours Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0602GC	Texas Health Resources FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0619GC	Ochsner Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0620G	King & Spalding FFY 2018 Two-Midnight IPPS Rate Group
18-0712GC	Henry Ford Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0713GC	UAB Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0825GC	WellStar Health System FFY 2018 Two-Midnight IPPS Rate CIRP Group
18-0899GC	CHRISTUS Health FFY 2018 Two-Midnight IPPS Rate CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: MCG Medical Center (Provider No. 11-0034)
FYE 6/30/2008
Case No. 13-2730

Dear Mr. Ravindran and Ms. Huggins,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the documents in case number 13-2730 in response to the jurisdictional challenges filed by the Medicare Contractor. The decision of the Board is set forth below.

Background

On February 14, 2013, the Provider, MCG Medical Center, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 6/30/2008. The Provider filed its appeal request with the Board on August 13, 2013, and appealed eight issues. The Provider later requested to transfer issues to various group appeals, including the SSI Systemic Errors issue to Case No. 13-2694GC. On March 28, 2014, the Provider submitted its preliminary position paper which identified four issues: SSI Provider Specific; Medicaid Eligible days; Medicare Crossover Bad Debts; and Medicaid Eligible Observation Bed days. On November 25, 2015, the Provider requested to withdraw the Medicaid Eligible days issue subject to Board Rule 46.

On June 29, 2018, the Provider submitted its final position paper and identified the following four issues:

1. Whether the correct SSI percentage was used in the DSH calculation;
2. Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such says were paid days;
3. Whether allowable Bad Debts from Medicare Crossover were included when the Medicare Cost Report was audited per the Provider Reimbursement Manual, Part 1, § 322; and
4. Whether the MAC properly excluded Medicaid Eligible Observation Bed Days from the Providers' DSH calculation.

The Medicare Contractor filed a jurisdictional challenge over the remaining issues in the appeal on September 14, 2018, to which the Provider responded on October 12, 2018.

Medicare Contractor's Jurisdictional Challenge

Medicaid Eligible Days

The Medicare Contractor notes at the beginning of its jurisdictional challenge that the Provider included the Medicaid eligible days issue in its final position paper, even though it previously withdrew the issue. The Medicare Contractor reserves its right to challenge jurisdiction over the issue should the Provider seek reinstatement of the issue.[1]

DSH/SSI Provider Specific Issue

The Medicare Contractor argues that the SSI Provider Specific issue is duplicative of the SSI percentage issue that the Provider transferred to Case No. 13-2694G and that, therefore, the Board should find that it does not have jurisdiction over the SSI Systemic Errors issue. Additionally, the Medicare Contractor argues that the Board does not have jurisdiction over the portion of the Provider's issue statement as it relates to realignment of the SSI percentage. The Medicare Contractor requests that the Board dismiss this issue consistent with other jurisdictional decisions.[2]

Medicaid Eligible Observation Bed Days

The Medicare Contractor argues that the Board does not have jurisdiction over the observation bed days issue because it did not adjust these days on the Provider's cost report. The Medicare Contractor explains that observation bed days were reviewed during the desk review and that all the days claimed on the Provider's as-filed cost report were allowed. It concludes that because the Provider is asking for days that were not included on its as-filed cost report, it could not have issued a final determination and that, therefore, the Board does not have jurisdiction over the issue pursuant to 42 C.F.R. § 405.1835(a)(1).[3]

Medicare Crossover Bad Debts

The Medicare Contractor argues that the Board does not have jurisdiction over the Medicare Crossover Bad Debts issue because the Medicare Contractor did not render a final determination with respect to these days. Indeed, the Medicare Contractor could not make that determination because the Provider did not claim them on its cost report. Additionally, the Medicare Contractor asserts that the Provider cannot rely on CMS Ruling 1727-R because the Provider's appeal of this issue is not a legal challenge to the validity of a regulation or payment policy.[4]

[1] Medicare Contractor Jurisdictional Challenge at 2.
[2] *Id.* at 2-3.
[3] *Id.* at 4.
[4] *Id.* at 7.

Provider's Contentions

SSI Provider Specific

The Provider argues that the SSI Provider Specific and SSI Systemic Errors issues represent different components of the SSI issue and that, therefore, the Board should find jurisdiction over both issues. The SSI Systemic errors issue address the various errors discussed in *Baystate Med. Ctr. v. Leavitt*,[5] in CMS' calculation of DSH, which results in the MedPAR not reflecting all individuals who are eligible for SSI benefits.[6] With respect to the SSI Provider Specific issue, the Provider asserts that it is addressing the various errors of omission and commission that do not fit into the systemic errors category. The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI and has reason to believe that the SSI percentage determined by CMS is understated. According to the Provider, both of these are separate issues and the Board should find that it has jurisdiction over them.

Medicaid Observation Bed Days

The Provider states the Board has jurisdiction over the DSH Medicaid Eligible Observation Bed Days issue. The Provider contends that an inaccurate number of these days was included in both the numerator and denominator of its DSH Medicaid fraction and that, therefore, its DSH reimbursement is understated. The Provider's position is that the Board has jurisdiction over these days because the presentment/protest requirement of 42 C.F.R. § 405.1835(a) (and Board Rule 7.2(C)) are invalid and not applicable pursuant to the Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[7] The Provider makes other arguments in its Jurisdictional Response, including that the DSH payment adjustment is not an item which must be claimed or adjusted on the cost report.

Medicare Crossover Bad Debts

The Provider argues that the Board has jurisdiction over the Medicare Crossover Bad Debts issue because there is an adjustment to bad debts at Adjustment No. 21, which is enough to give rise to jurisdiction over the additional bad debts issue. The Provider also argues that the Secretary's reliance on her "must bill" policy (that a provider must bill and receive a remittance advice from the State in cases where the State owes nothing or only a portion of a dual eligible patient's Medicare deductible or copayment) allows the Provider to rely on the *Bethesda* rationale for jurisdiction.

[5] 545 F. Supp. 2d 20 (D.D.C. 2008).
[6] Provider's Jurisdictional Response at 2.
[7] 485 U.S. 399 (1988).

BOARD'S DECISION:

SSI Provider Specific

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

In its appeal request, the Provider summarizes its SSI "provider-specific" issue in the following manner:

> The Provider contends that its[] SSI percentage published by the Centers for Medicare [&] Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]. . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.

With respect to the SSI "systemic" issue, the Provider states the issue as, "Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage. The Provider sets out numerous reasons why it claims CMS improperly computed its SSI percentage:

1. The Secretary improperly included exhausted benefit and Medicare Secondary Payor days in the SSI fraction;

2. The Secretary improperly included Medicare Advantage Part C days in the SSI fraction;

3. The Secretary used an improper matching methodology in computing the SSI fraction; and

4. The Secretary failed to adhere to the required notice and comment rulemaking procedures.

In its SSI "provider specific" issue statement and Final Position Paper, the Provider fails to describe any additional reasons or patient populations "entitled to SSI benefits" that would distinguish these two issues from each other or in any way differentiate these issues in a significant manner. The Board concludes, therefore, that the SSI "systemic errors" and "provider specific" issues challenge the same data underlying the SSI percentage calculation and are, ultimately, the same issue.

In addition, although the Provider's SSI "provider-specific" issue statement includes a proclamation that Central Connecticut "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board notes that the right to *request* realignment of its fiscal year for the SSI percentage calculations is a provider election and is not an appealable issue before the Board as there is not final determination.[8] The Provider included a copy of the Request for Realignment of SSI Patient Percentage that it submitted to the Medicare Contractor in accordance with 42 C.F.R. § 412.106(b)(3), which further confirms there is not final determination on realignment being appealed, but rather there is a pending provider election that has yet to complete review by the Medicare Contractor.[9]

Medicaid Observation Bed Days

As set forth below, the Board finds that it does not have jurisdiction over the Medicaid Observation Bed Days issue.

According to the Medicare Contractor, the Provider claimed some observation bed days on its cost report, which were allowed at the desk audit, and the Provider is now claiming additional observation bed days which were not initially claimed on its cost report. In its Final Position Paper, the Provider states:

> The Provider requests that the MAC review the Listing of Patient Days being send [sic] under separate cover. The Provider contends that the days on the Listings should be included in both the numerator and denominator of the DSH calculations as the patients were Medicaid eligible and/or the charges for these days were included in the UB-04.[10]

42 U.S.C. § 1395oo(a) dictates that to obtain jurisdiction, a provider must be "dissatisfied" with a "final determination" of the Medicare contractor. Thus, it follows that a provider must have claimed reimbursement for items and services in order for the Medicare contractor to make a "final determination" regarding such items and services. The Board generally has interpreted 42 U.S.C. § 1395oo(a) as the gateway to establishing Board jurisdiction to hear an appeal and requiring a provider to establish a right to appeal on a claim-by-claim or issue-specific basis. In *Saint Vincent Indianapolis Hosp. v. Sebelius* ("*St. Vincent Indianapolis*"),[11] the U.S. District Court for D.C. upheld the Board's interpretation of the dissatisfaction requirement.

The operation of the jurisdictional gateway established by 42 U.S.C § 1395oo(a) was addressed by the Supreme Court in *Bethesda*. The narrow facts of the *Bethesda* controversy dealt with the

[8] *See* 42 C.F.R. § 412.106(b)(3) (2015).
[9] Letter dated May 25, 2018 from the Provider to the Medicare Contractor.
[10] Provider's Final Position Paper at 12 (June 28, 2018).
[11] 134 F. Supp. 3d 238 (D.D.C. 2015).

self-disallowed apportionment of malpractice insurance costs.[12] The provider failed to claim the cost because a regulation dictated it would have been disallowed. In that situation, the Supreme Court found § 1395oo(a) permitted jurisdiction over the "self-disallowed" claim. The Supreme Court wrote:

> [U]nder subsection (a)(1)(A)(i), a provider's dissatisfaction with the amount of its total reimbursement is a condition to the Board's jurisdiction. It is clear, however, that the *submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations.*[13]

The Supreme Court recognized that a situation where a regulation pre-determines a disallowance is distinct from those in which a provider simply neglects to include an item on the cost report for which it would be due reimbursement:

> Thus, petitioners stand on different ground than do providers who bypass a clearly prescribed exhaustion requirement or *who fail to request from the [Medicare contractor] reimbursement for all costs to which they are entitled under applicable rules.* While such defaults might well establish that a provider was satisfied with the amounts requested in its cost report and awarded by the [Medicare contractor], those circumstances are not presented here.[14]

Here, the Board finds that there was no legal impediment preventing the Provider from claiming additional observation bed days on its cost report, especially taking into account the fact that it claimed some, which the Medicare Contractor allowed. Additionally, CMS clarified its position regarding including observation bed days in DSH if the patient is ultimately admitted in the 2005 IPPS Final Rule, which stated:

> In summary, in this final rule we are adopting the proposed changes to Sec. 412.105(b) and Sec. 412.106(a)(1)(ii), which specify that observation and swing-bed days are to be excluded from the counts of both available bed days and patient days unless a patient receiving outpatient observation services in a bed that is generally used to provide hospital inpatient acute care services is ultimately admitted, in which case the beds and days associated with the observation services would be included in those counts.

[12] *Bethesda*, 485 U.S. at 401-402.
[13] *Id.* at 404 (emphasis added).
[14] *Id.* at 404-405 (emphasis added).

> This policy will be effective for cost reporting periods beginning on or after October 1, 2004.[15]

Therefore, the Board finds that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) over the observation bed days issue.

In addition to addressing jurisdiction under 42 U.S.C. § 1395oo(a), the Board has historically addressed whether to exercise its discretion under § 1395oo(d).[16] Specifically, when the Board finds that it does not have jurisdiction under § 1395oo(a) over a particular appealed issue/item but does have jurisdiction under § 1395oo(a) over at least one *other* appealed issue/item, then the Board has considered whether to exercise discretion under § 1395oo(d) to hear that particular issue/item. As discussed more fully in the Board's decision underlying *St. Vincent Indianapolis*, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving *unclaimed* costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs.[17] As this same situation occurs in this case, the Board hereby declines to exercise discretion under § 1395oo(d) in this case.

Medicare Crossover Bad Debts

The Board finds that it does not have jurisdiction over the Medicare Crossover Bad Debts issue because the Provider did not claim the days and was not barred from doing so. In its Final Position Paper the Provider states:

> When the Provider's FYE 6/30/2008 Medicare cost report was filed, the Provider failed to include all the Medicare crossover bad debts that it had occurred during the fiscal year. When the FYE 06/30/2008 cost report was audited the MAC failed to include all of the Medicare crossover bad debts that the Provider had incurred during the fiscal year. Since the cost report was audited, the Provider became aware of these unclaimed Medicare crossover bad debts and subsequently added them to the appeal pending before the Board.[18]

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[15] 69 Fed. Reg. 48915, 49097-98 (Aug. 11, 2004).

[16] Note that, in the final rule issued on May 23, 2008, the Secretary revised the Board's regulations to limit the Board's authority under 42 U.S.C § 1395oo(d) through the promulgation of the regulation at 42 C.F.R. § 405.1869(a) (*see* 73 Fed. Reg. 30190, 30225-30226 (May 23, 2008)). However, this revision does not appear to be applicable to this case as it is the Board's understanding that this revision applies to cost reporting periods beginning on or after October 1, 2008.

[17] *See St. Vincent Hospital & Health Center v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2013-D39 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).

[18] Provider Final Position Paper at 9.

Again, there was no legal impediment preventing the Provider from claiming the additional crossover bad debts on its cost report. The Provider states in its final position paper that it simply became aware of the bad debts after the cost report was audited. Based on these facts, the Board finds that it does not have jurisdiction over the additional crossover bad debts because the Provider does not meet the dissatisfaction requirement.

The failure to claim bad debts was addressed by the First Circuit in the decisions for *MaineGeneral Med Ctr. v. Shalala* ("*MaineGeneral*")[19] and *Saint Luke's Hosp. v. Secretary* ("*St. Luke's*").[20] *MaineGeneral* involved hospitals that listed zero for reimbursable bad debts on their cost reports. The mistake was not discovered until after the NPRs had been issued. The providers appealed several items adjusted by the NPRs, but also included a claim for bad debts. The Board dismissed the bad debts claim for lack of jurisdiction because they had not been disclosed on the cost report, despite there being no legal impediment to doing so. In *MaineGeneral*, the First Circuit relied on its prior decision in *St. Luke's* in which costs were self-disallowed. It found that its *St. Luke's* decision had addressed the question of whether the Board has the power to decide an issue that was not first raised before the Medicare contractor and held that it does, but that the power is discretionary under 42 U.S.C. § 1395oo(d). Accordingly, in *St. Luke's*, the First Circuit expressly rejected the provider's assertion that the court should order the Board to hear the case, even though it found the hospitals had a strong equitable argument favoring review.[21] Using this analysis, the First Circuit found in *MaineGeneral* that the Board could adopt a policy of hearing such claims by either refusing to hear them, or opting to decide on a case-by-case basis. The First Circuit further noted that "a rule of consistently refusing to hear inadvertently omitted claims would be rational; given the ability of providers to request the [Medicare contractor] to reopen an NPR up to three years after it has been issued."[22]

As discussed above, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeals of other issues involving *unclaimed* costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs.[23] As this same situation occurs in this case, the Board hereby declines to exercise discretion under § 1395oo(d).

Conclusion

The Board finds that it does not have jurisdiction over any of the remaining issues in Case No. 13-2730. The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the Systemic Errors issue that was transferred to a group appeal and because the realignment portion of the issue statement is not an appealable issue.

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[19] 205 F.3d 498 (1st Cir. 2000).
[20] 810 F.3d 325 (1st Cir. 1987).
[21] *St. Luke's* at 322.
[22] *MaineGeneral* at 501.
[23] *See St. Vincent Hospital & Health Center v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2013-D39 (September 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).

The Board finds that it does not have jurisdiction over either the Medicaid Eligible Observation Bed Days issue or the Medicare Crossover Bad Debts issues because the Provider did not claim these days on its cost report and there was no legal impediment to doing so. The Board further declines to exercise jurisdiction under 42 U.S.C. § 1395oo(d) to hear these issues.

Last, the Board notes that, although the Provider briefed the Medicaid eligible days issue in its Final Position Paper, the record for this case shows that the Provider had previously withdrawn the issue. Accordingly, the Medicaid eligible days issue is no longer pending in Case No. 13-2730.

As no issues remain pending in the appeal, the Board hereby closes Case No. 13-2730 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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FOR THE BOARD:

7/19/2019

X Clayton J. Nix

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RE: MCG Medical Center (Provider No. 11-0034)
FYE 6/30/2010
Case No. 14-2695

Dear Mr. Ravindran and Ms. Huggins,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the documents in case number 14-2695 in response to the jurisdictional challenges filed by the Medicare Contractor. The decision of the Board is set forth below.

Background

On August 29, 2013, the Provider, MCG Medical Center, was issued an original Notice of Program Reimbursement ("NPR") for fiscal year end ("FYE") 6/30/2010. The Provider filed its appeal request with the Board on February 28, 2014, and appealed 10 issues. The Provider later requested to transfer issues to various group appeals, including the SSI Systemic Errors issue to Case No. 14-1815G. On August 9, 2017, the Provider requested to withdrawn the Medicaid Eligible days issue subject to Board Rule 46.

The Provider submitted its final position paper on March 20, 2018, which identified four issues:

1. Whether the correct SSI percentage was used in the DSH calculation;
2. Whether the numerator of the "Medicaid fraction" properly includes all "eligible" Medicaid days, regardless of whether such says were paid days;
3. Whether allowable Bad Debts from Medicare Crossover were included when the Medicare Cost Report was audited per the Provider Reimbursement Manual, Part 1, § 322; and
4. Whether the MAC properly excluded Medicaid Eligible Observation Bed Days from the Providers' DSH calculation.

The Medicare Contractor filed a jurisdictional challenge over the remaining issues in the appeal on September 14, 2018, to which the Provider responded on October 12, 2018.

Medicaid Eligible Days

The Medicare Contractor notes at the beginning of its jurisdictional challenge that the Provider included the Medicaid eligible days issue in its final position paper, even though it previously withdrew the issue. The Medicare Contractor reserves its right to challenge jurisdiction over the issue should the Provider seek reinstatement of the issue.[1]

DSH/SSI Provider Specific Issue

The Medicare Contractor argues that the SSI Provider Specific issue is duplicative of the SSI percentage issue that the Provider transferred to Case No. 14-1815G and that, therefore, the Board should find that it does not have jurisdiction over the SSI Systemic Errors issue. Additionally, the Medicare Contractor argues that the Board does not have jurisdiction over the portion of the Provider's issue statement as it relates to realignment of the SSI percentage because the Provider's appeal is premature as the Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Medicare Contractor requests that the Board dismiss this issue consistent with other jurisdictional decisions.[2]

Medicaid Eligible Observation Bed Days

The Medicare Contractor argues that the Board does not have jurisdiction over the observation bed days issue because the Medicare Contractor did not adjust these days on the Provider's cost report. The Medicare Contractor explains that observation bed days were reviewed during the desk review and that all the days claimed on the Provider's as-filed cost report were allowed. It concludes that, because the Provider is asking for days that were not included on its as-filed cost report, it could not have issued a final determination and the Board does not have jurisdiction over the issue pursuant to 42 C.F.R. § 405.1835(a)(1).[3]

The Medicare Contractor also argues that CMS Ruling 1727-R is not applicable to the Provider's appeal of Medicaid Eligible Observation Bed Days because the issue is not similar to *Banner* in that the Provider's appeal is not a legal challenge to the validity of a regulation or payment policy.[4] It also argues that an issue is not similar to *Banner* simply because the Medicare Contractor is bound by a regulation or payment policy when settling the Provider's cost report.[5] According to the Medicare Contractor, the Provider is pointing to the observation bed day payment regulation and is challenging the Medicare Contractor's application of that regulation, which does not fall under CMS Ruling 1727-R.

[1] Medicare Contractor Jurisdictional Challenge at 2.
[2] *Id.* at 3-4.
[3] *Id.* at 5.
[4] *Id.* at 9.
[5] *Id.* at 10.

Medicare Bad Debts

The Medicare Contractor is challenging jurisdiction over whether it properly determined the Provider's Medicare reimbursement for allowable bad debts including uncollectable accounts, crossover accounts, and accounts that qualify for charity.[6] It argues that that it did not disallow charity care bad debts or bad debts at a collection agency or bad debts due to untimely billing and that it did not improperly exclude crossover bad debts. The Medicare Contractor argues that the Provider included $1,003,500 dual eligible bad debts in Part A bad debts on Worksheet E, Part A, Line 21.02 and $688,765 dual eligible bad debts in Part B bad debts on Worksheet E, Part B, Line 27.02 and argues that the Provider is now requesting additional crossover bad debts that were not initially included on the cost report.[7] The Medicare Contractor argues that it did not render a final determination with respect to these additional bad debts and that, therefore, the Board should find that it does not have jurisdiction.

The Medicare Contractor also makes the argument that CMS Ruling 1727-R is not applicable to the bad debts issue because the Provider's appeal is not a legal challenge to the validity of a regulation or payment policy.[8]

Provider's Contentions

SSI Provider Specific

The Provider argues that the SSI Provider Specific/Realignment and SSI Systemic Errors issues represent different components of the SSI issue and that, therefore, the Board should find jurisdiction over both issues. The SSI Systemic errors issue address the various errors discussed in *Baystate Med. Ctr. v. Leavitt*,[9] in CMS' calculation of DSH, which results in the MedPAR not reflecting all individuals who are eligible for SSI benefits.[10] With respect to the SSI Provider Specific issue, the Provider asserts that it is addressing the various errors of omission and commission that do not fit into the systemic errors category. The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI and has reason to believe that the SSI percentage determined by CMS is understated. According to the Provider, both of these are separate issues and the Board should find that it has jurisdiction over them.

Medicaid Observation Bed Days

The Provider argues that the Board has jurisdiction over the observation bed days because there was an adjustment to the Provider's DSH and Medicaid Days at Adjustment Nos. 16, 20, 21, and 30, which is enough to warrant Board jurisdiction over the appeal issue. The Provider also claims that the adjustment is not required, because DSH is not an item that has to be adjusted or

[6] *Id.* at 12.
[7] *Id.*
[8] *Id.* at 17.
[9] 545 F. Supp. 2d 20 (D.D.C. 2008).
[10] Provider's Jurisdictional Response at 2.

claimed on a cost report.[11] The Provider's position is that the Board has jurisdiction over these days because the presentment/protest requirement of 42 C.F.R. § 405.1835(a) (and Board Rule 7.2(C)) are invalid and not applicable pursuant to the Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*"[12]).[13] The Provider makes other arguments in its Jurisdictional Response, including that the DSH payment adjustment is not an item which must be claimed or adjusted on the cost report.

Medicare Crossover Bad Debts

The Provider argues that the Board has jurisdiction over the Medicare Crossover Bad Debts issue because the issuance of the NPR and timely appeal properly triggers the Board's jurisdiction over the appeal. The Provider also argues that the Secretary's reliance on her "must bill" policy (that a provider must bill and receive a remittance advice from the State in cases where the State owes nothing or only a portion of a dual eligible patient's Medicare deductible or copayment) allows the Provider to rely on the *Bethesda* rationale for jurisdiction.[14]

The Provider did not address the Board's jurisdiction over charity care bad debts, which it briefed in its Final Position Paper, and was challenged by the Medicare Contractor.

BOARD'S DECISION

Pursuant to 42 C.F.R. §§ 405.1835-405.1840 (2009), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare Contractor, the amount in controversy is $10,000 or more, and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2008), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either: (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

The Administrator issued CMS-1727-R in April 2018 to provide certain exceptions to the § 405.1835(a)(1) requirement. As described on the first page of the Ruling, the Ruling "states the policy of [CMS] concerning the CMS decision to follow the U.S. District Court for the District of Columbia's holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) . . . ." Further on in that same paragraph, the Ruling provides the following description for how it largely follows *Banner*:

> [F]or appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016[,] that were

[11] *Id.* at 3.
[12] 485 U.S. 399 (1988).
[13] *Id.* at 4-5.
[14] *Id.* at 7.

> pending or filed on or after April 23, 2018[,] a provider has a right to a [Medicare Contractor] or [PRRB] hearing for an item the provider did not include on its cost report *due to **a good faith belief** that the item was subject to a payment regulation or other policy that gave the [Medicare Contractor] **no authority or discretion** to make payment in the manner the provider sought*.[15]

SSI Provider Specific

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

In its appeal request, the Provider summarizes its SSI "provider-specific" issue in the following manner:

> The Provider contends that its[] SSI percentage published by the Centers for Medicare [&] Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation[.]. . . The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.

With respect to the SSI "systemic" issue, the Provider states the issue as, "Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage. The Provider sets out numerous reasons why it claims CMS improperly computed its SSI percentage:

1. The Secretary improperly included exhausted benefit and Medicare Secondary Payor days in the SSI fraction;
2. The secretary improperly included Medicare Advantage Part C days in the SSI fraction;
3. The Secretary used an improper matching methodology in computing the SSI fraction; and
4. The Secretary failed to adhere to the required notice and comment rulemaking procedures.

In its SSI "provider specific" issue statement and Final Position Paper, the Provider fails to describe any additional reasons or patient populations "entitled to SSI benefits" that would distinguish these two issues from each other or in any way differentiate these issues in a significant manner. The Board concludes, therefore, that the SSI "systemic errors" and "provider specific" issues challenge the same data underlying the SSI percentage calculation and are, ultimately, the same issue.

[15] CMS-1727-R at unnumbered page 2 (emphasis added).

In addition, although the Provider's SSI "provider-specific" issue statement includes a proclamation that Central Connecticut "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board notes that the right to request realignment of its fiscal year for the SSI percentage calculations is a provider election and is not an appealable issue before the Board as there is no final determination.[16] The Provider included a copy of the Request for Realignment of SSI Patient Percentage that it submitted to the Medicare Contractor in accordance with 42 C.F.R. § 412.106(b)(3), which further confirms the Board's decision that this is not an appealable issue, but rather there is a pending provider election that has yet to complete review by the Medicare Contractor.[17]

Medicaid Observation Bed Days

As set forth below, the Board finds that it does not have jurisdiction over the Medicaid Observation Bed Days issue.

According to the Medicare Contractor, the Provider claimed some observation bed days on its cost report, which were allowed at the desk audit, and the Provider is now claiming *additional* observation bed days which were not initially claimed on its cost report. In its Final Position Paper, the Provider states:

> The Provider requests that the MAC review the Listing of Patient Days being send [*sic*] under separate cover. The Provider contends that the days on the Listings should be included in both the numerator and denominator of the DSH calculations as the patients were Medicaid eligible and/or the charges for these days were included in the UB-04.[18]

In the instant appeal, the claim/protest requirements of 42 C.F.R. § 405.1835(a)(1) were in effect during the time at issue but there is nothing in the record to suggest that the Provider claimed or protested the additional observation bed days in compliance with § 405.1835(a)(1).

In the section entitled "IMPLEMENTATION . . . ," CMS-1727-R sets out a five-step analysis for the Board to undertake in order to determine whether a provider is entitled to a PRRB hearing for an item that the provider appealed but did not include on its cost report. The first step in the analysis involves the appeal's filing date and cost reporting period. A provider's PRRB appeal pending or filed on or after April 23, 2018, that concerns a cost reporting period ending on or after December 31, 2008, and beginning before January 1, 2016, is subject to the five-step analysis set out in CMS-1727-R. In the instant appeal, the Board received the Provider's appeal request concerning its FYE June 30, 2010 cost reporting period on February 28, 2014.

[16] *See* 42 C.F.R. § 412.106(b)(3) (2015).
[17] Letter dated May 25, 2018 from the Provider to the Medicare Contractor.
[18] Provider's Final Position Paper at 12 (June 28, 2018).

Second, the Board must determine whether the appealed item "was ***subject to*** *a regulation* ***or*** *other 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."[19] Here, the Board finds that there was no legal impediment preventing the Provider from claiming additional observation bed days on its cost report, especially taking into account the fact that it claimed some, which the Medicare Contractor allowed. Additionally, CMS clarified its position regarding including observation bed days in DSH if the patient is ultimately admitted in the 2005 IPPS Final Rule, which stated:

> In summary, in this final rule we are adopting the proposed changes to Sec. 412.105(b) and Sec. 412.106(a)(1)(ii), which specify that observation and swing-bed days are to be excluded from the counts of both available bed days and patient days unless a patient receiving outpatient observation services in a bed that is generally used to provide hospital inpatient acute care services is ultimately admitted, in which case the beds and days associated with the observation services would be included in those counts. This policy will be effective for cost reporting periods beginning on or after October 1, 2004.[20]

Therefore, the Board finds that the mandates of the ruling are not applicable because the Provider was not barred by a regulation or other payment policy from claiming observation bed days and concludes that it does not have jurisdiction over the issue under 42 U.S.C. § 1395oo(a) because the days were not claimed or protested.

The Board recognizes that, notwithstanding the lack of jurisdiction under 42 U.S.C. § 1395oo(a), there is an issue of whether the Board could exercise discretion under 42 U.S.C. § 1395oo(d) to still hear the crossover bad debt issue. In this regard, the Board recognizes that there are a number of federal cases that discuss the Board's discretionary authority under § 1395oo(d) in fairly broad terms (including *MaineGeneral* and the Supreme Court's decision in *Bethesda*). The Board discusses some of these cases in its 2013 decision in *St. Vincent Hosp. & Health Ctr. V. Blue Cross Blue Shield Ass'n* ("*SVHHC*").[21] However, the Board also recognizes that CMS promulgated 42 C.F.R. § 405.1869(a) in May 23, 2008 to limit the Board's authority under § 1395oo(d) and that § 405.1869(a) is applicable to this case. Specifically, § 405.1869(a) appears to limit the Board's discretionary authority under § 1395oo(d) to specific matters over which the Board has jurisdiction under § 1395oo(a) or (b) ***and*** which are *timely* raised either in the hearing request or a request to add issues to an otherwise properly pending appeal. However, the Board need not resolve this conflict because it is clear that the Provider failed to claim the observation bed days at issue due to error or inadvertence and, as discussed in *SVHHC*, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole

[19] CMS-1727-R at unnumbered page 6 (emphasis added).
[20] 69 Fed. Reg. 48915, 49097-98 (Aug. 11, 2004).
[21] PRRB Dec. No. 2013-D39 at 13-16 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013).

issue(s) in the case involves unclaimed costs. Accordingly, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue to the extent the Board is not barred from exercising that discretion pursuant to 42 C.F.R. § 405.1869(a).

Medicare Crossover Bad Debts

The Board finds that it does not have jurisdiction over the Medicare Crossover Bad Debts issue because the Provider did not claim the days and was not barred from doing so. In its Final Position Paper, the Provider states:

> When the Provider's FYE 6/30/2010 Medicare cost report was filed, the Provider failed to include all the Medicare crossover bad debts that it had occurred during the fiscal year. When the FYE 06/30/2010 cost report was audited the MAC failed to include all of the Medicare crossover bad debts that the Provider had incurred during the fiscal year. Since the cost report was audited, the Provider became aware of these unclaimed Medicare crossover bad debts and subsequently added them to the appeal pending before the Board.[22]

Further, the Provider states in its final position paper that it simply became aware of the bad debts after the cost report was audited. The Board finds that there was no legal impediment preventing the Provider from claiming the additional crossover bad debts on its cost report. Based on these facts, the Board concludes that it does not have jurisdiction under 42 U.S.C. § 1395oo(a) over the additional crossover bad debts because the Provider does not meet the dissatisfaction requirement.

The Board also finds that CMS Ruling 1727-R is not applicable to the Medicare Crossover Bad Debts issue because the Provider was not barred by a regulation or other payment policy from claiming the days on its cost report. As such, the Board concludes that it does not have jurisdiction over the issue under 42 U.S.C. § 1395oo(a) because the Medicare Crossover Bad Debts issue was neither claimed nor protested.

Finally, similar to its findings on observation bed days issue, it is clear that the Provider failed to claim the crossover care bad debts at issue due to error or inadvertence and, as discussed in *SVHHC*, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs. Accordingly, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue to the extent the Board is not barred from exercising that discretion pursuant to 42 C.F.R. § 405.1869(a).

[22] Provider Final Position Paper at 9.

Charity Care Bad Debts

The Board finds that it does not have jurisdiction over the charity care bad debts issue because the Provider did not claim or protest these days on its cost report. In its Final Position Paper the Provider states:

> Provider's Medicare charity care bad debts claimed were disallowed because the MAC claimed that all four (4) tests to determine indigency (assets, liabilities, income, and expenses) were not performed and not properly documented or because Medicaid eligibility verification was not completed.

The audit adjustment report documents submitted to the Board with this appeal do not show any adjustments to remove charity care bad debts. Additionally, the Medicare Contractor states in its Final Position Paper that the Provider is incorrect in this statement, and that it did not make any adjustments to bad debts prior to the settlement of the current cost report.[23]

The Board also finds that CMS Ruling 1727-R is not applicable to the charity care bad debts issue because the Provider was not barred by a regulation or other payment policy from claiming the days on its cost report.

Finally, similar to its findings on observation bed days issue, it is clear that the Provider failed to claim the charity care bad debts at issue due to error or inadvertence and, as discussed in *SVHHC*, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs. Accordingly, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue to the extent the Board is not barred from exercising that discretion pursuant to 42 C.F.R. § 405.1869(a).

Conclusion

The Board finds that it does not have jurisdiction over any of the remaining issues in Case No. 14-2695. The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the Systemic Errors issue that was transferred to a group appeal and because the realignment portion of the issue statement is not an appealable issue.

The Board finds that it does not have jurisdiction over the following three issues because the Provider did not claim these days on its cost report and there was no legal impediment to doing so: (1) Medicaid Eligible Observation Bed Days issue; (2) the Medicare Crossover Bad Debts issue; and (3) the Charity Care Bad Debts issue.

Last, the Board notes that, although the Provider briefed the Medicaid eligible days issue in its Final Position Paper, the record in this case shows that the Provider had previously withdrawn

[23] Medicare Contractor Final Position Paper at 18.

the issue. Accordingly, the Medicaid eligible days issue is no longer pending in Case No. 14-2695.

As no issues remain pending in the appeal, the Board hereby closes Case No. 14-2695 is hereby and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

BOARD MEMBERS PARTICIPATING:

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FOR THE BOARD:

7/19/2019

X Clayton J. Nix

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Chair
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RE: ***Jurisdictional Determination*** **-** *St. Joseph's Health System LIP Group Appeals*
FYEs 2010-14
Case Nos. 15-1837GC, *et al.* (*see* Appendix A for a listing of appeals)

Dear Mr. Knight, Mr. Chinea, and Ms. Frewert:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2010 through 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the June 8, 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

The Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2010 through 2014. In its RFHs, the Providers' list a single issue for appeal — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs"). The cases involved are listed in **Appendix A**.

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy*, answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the D.C. District Court, wherein the D.C. District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] 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.[5]

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[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

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

Board Members Participating:

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

For the Board:

7/19/2019

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

[6] 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).

Appendix A

Case Number	Case Name	FYE
15-1837GC	St. Joseph Health System 2010 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio CIRP	12/31/2010
18-1454GC	SJHS 2011 LIP Inclusion of Medicare Part C Days in SSI Ratio CIRP Group	6/30/2011
18-1456GC	SJHS 2011 LIP Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group	6/30/2011
18-0050GC	St. Joseph Health System 2012 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	6/30/2012
18-0051GC	St. Joseph Health System 2012 LIP Exclusion of Dual Eligible Part A Unpaid Days from Medicaid Ratio CIRP Group	6/30/2012
18-0052GC	St. Joseph Health System 2012 LIP Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group	6/30/2012
18-0054GC	St. Joseph Health System 2012 LIP Inclusion of Medicare Part C Days in SSI Ratio CIRP Group	6/30/2012
18-0053GC	St. Joseph Health System 2012 LIP Inclusion of Part A Unpaid Days in SSI Ratio CIRP Group	6/30/2012
17-0547GC	St. Joseph Health System 2013 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	6/30/2013
17-0548GC	St. Joseph Health System 2013 LIP Exclusion of Dual Eligible Part A Unpaid Days from the Medicaid Ratio CIRP Group	6/30/2013
17-0550GC	St. Joseph Health System 2013 LIP Exclusion of Dual Eligible Part C Days from the Medicaid Ratio CIRP Group	6/30/2013
17-0549GC	St. Joseph Health System 2013 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio CIRP Group	6/30/2013
17-0551GC	St. Joseph Health System 2013 LIP Inclusion of Medicare Part C Days in SSI Ratio CIRP Group	6/30/2013
17-1342GC	St. Joseph HS 2014 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	6/30/2014
17-1343GC	St. Joseph HS 2014 LIP Exclusion of Dual Eligible Part A Unpaid Days from Medicaid Ratio CIRP Group	6/30/2014
17-1344GC	St. Joseph HS 2014 LIP Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group	6/30/2014
17-1345GC	St. Joseph HS 2014 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio CIRP Group	6/30/2014
17-1346GC	St. Joseph HS 2014 LIP Inclusion of Medicare Part C Days in SSI Ratio CIRP Group	6/30/2014

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Electronic Mail

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

RE: ***Expedited Judicial Review Determination***
18-0214GC Health Alliance of the Hudson Valley 2007-2012 Medicare HMO Part C Days - Medicaid Fract. CIRP Grp
18-0216GC Health Alliance of the Hudson Valley 2007-2012 Medicare HMO Part C Days - Medicare Fract. CIRP Grp

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 26, 2019 request for expedited judicial review ("EJR") (received June 27, 2019), for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Providers' EJR request at 1.

prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . . (emphasis added)

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

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[11] 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

[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.

> Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

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

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[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] 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.
[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[20] 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."[21]

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[17] 69 Fed. Reg. at 49,099.
[18] *Id*.
[19] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[20] 72 Fed. Reg. at 47411.
[21] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[22] 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.[23] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[24] 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*.[25] 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.[26] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

Decision of the Board

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

Improper Inclusion of Previously Dismissed Providers on the Schedule of Providers

At the outset, the Board notes that the Schedule of Providers submitted by the Provider Representative with the EJR requests for Case Nos. 18-0214GC and 18-0216GC each ***improperly*** include the same original NPR appeal for Provider 8 (St. Mary's Avenue Campus, Provider No.

[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[24] 863 F.3d 937 (D.C. Cir. 2017).
[25] *Id.* at 943.
[26] *Id.* at 943-945.

33-0224) for FYE 12/31/2012 that the Board previously had dismissed from its individual appeal prior to transfer.[27] Accordingly, this Providers original NPR appeal is not part of Case Nos. 18-0214GC and 18-0216GC and, as such, cannot be considered in this EJR request. Notwithstanding, the Board notes that the Provider still has pending in these group appeals a valid appeal from the failure to issue a timely NPR.[28]

Jurisdictional Determination for the Remaining Participants

The *remaining* participants in this EJR request have filed an appeals involving fiscal years 2007-2012.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of 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 Hosps Ass'n v. Bowen* ("*Bethesda*").[29] 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.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell*

[27] Provider 8, HealthAlliance Hospital – Mary's Avenue Campus filed an appeal on November 2,2014 from the Medicare Administrative Contractors failure to timely issue its NPR and PRRB Case No. 15-0596 was established. Four issues were appealed, including the Medicare HMO Part C days issue. On August 5, 2015, the Provider filed an appeal of its original NPR dated February 13, 2015, and the appeal of that final determination was consolidated in Case No. 15-0596. On September 20, 2016, the Board dismissed the issues appealed from the original NPR as they were not briefed as required in the Board's August 8, 2015 acknowledgement letter.

[28] The appeal of the issues from the Medicare Contractors failure to issue a timely NPR remains. The Provider withdrew this appeal on December 11, 2017 but only after transferring several issues, including the Part C issue, to group appeals. The schedule of providers *incorrectly* reflects a May 24, 2019 transfer date of the Part C issues to 18-0214GC and 18-0216GC. Rather, the correct filing date for these transfer requests is December 1, 2017, which occurred prior to the December 11, 2017 withdrawal of the individual appeal.

[29] 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.).

[30] *Bethesda at 1258-59.*

[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[32] 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.[33]

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

The Board has determined that jurisdiction over the *remaining* participants involved with the instant EJR request is governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2007-2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[34] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to

[32] 201 F. Supp. 3d 131 (D.D.C. 2016)
[33] *Banner* at 142.
[34] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

bring suit in either the D.C. Circuit *or* the circuit within which they are located.[35] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the remaining Providers are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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

[35] *See* 42 U.S.C. § 1395oo(f)(1).

FOR THE BOARD:

7/23/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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RE: ***EJR Determination-King & Spalding DGME Appeals***
See Appendix I for a List of Cases

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' requests for expedited judicial review ("EJR") received May 14, 2019, May 21, 2019 and May 29, 2019, as well as the Providers' June 24, 2019 response to the Board's June 13, 2010 request for additional information. The decision of the Board is set forth below.

The issue under appeal in each of these cases is:

> Whether the formula for calculating the number of full-time equivalent ("FTE") residents in a hospital may count in a year for the purposes of direct graduate medical education [DGME], as contained in 42 C.F.R. [§] 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train "fellows" (*i.e.*, residents who are not in their initial residency period) while operating in excess of their FTE caps. The Providers seek relief in the form of an adjustment to their FTE count for its present, prior and penultimate years.[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]

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

A hospital's "resident 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

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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).

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 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

[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).

> 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. . . .
>
> 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

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> 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:
>
> > (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

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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.

that year.[15] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

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:

> [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 contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. This reduction is accomplished by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). This results in the hospital's allowable FTE count. The Providers point out that the regulation only applies when hospitals report residents in excess of their cap level. Consequently, if a hospital's unweighted FTE count for allopathic and osteopathic residents is less than or equal to its cap, its weighted FTEs are not reduced.

The Providers assert that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Providers assert that the regulation produces absurd results. They explain that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Providers believe that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.

The Providers also note that they are seeking a correction of the allowable FTE counts for their prior and penultimate cost reporting years. Since the FTE counts from the prior and penultimate years were determined in cost reporting periods preceding the payment years under appeal, they may be considered "predicate facts." The Providers point out that the Centers for Medicare & Medicaid Services has interpreted the three-year limitations period in the reopening regulation at

[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.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).

42 C.F.R. § 405.1885(b)(2)(i) as prohibiting providers from appealing predicate facts in cost report appeals. However, that interpretation was recently rejected in *Saint Francis Medical Center v. Azar*[17] ("*St. Francis*") which concluded that "42 C.F.R. § 405.1885(b)(2)(i) does not apply to appeals from a fiscal intermediary to the PRRB."[18]

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. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[19] 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.[20]

On August 21, 2008, new regulations governing the Board were effective.[21] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[22] 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 D.C. District Court concluded that, under *Bethesda*, the 2008

[17] 894 F. 3d 290 (D.C. Cir. 2018).
[18] *Id.* at 297.
[19] 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.).
[20] *Bethesda*, 108 S. Ct. at 1258-59.
[21] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[22] 201 F. Supp. 3d 131 (D.D.C. 2016).

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.[23]

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

B. Background on Appeals of Precedent Facts

1. The 2013 Kaiser Case and CMS' Subsequent Revisions to 42 C.F.R. § 405.1885

In 2013, the D.C. Circuit issued its decision in *Kaiser Found. Hosp. v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[24] The *Kaiser* case also involved the statutory cap on IME FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates and adjustment to the closed year's reimbursement.[25]

CMS disagreed with the *Kaiser* decision, and, in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

> …we are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one

[23] *Id.* at 142.
[24] 708 F.3d 226, 232-233 (D.C. Cir. 2013).
[25] *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 229 (D.C. Cir. 2013).

> cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation, or other legal provision permitting reauditing, revising , or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[26]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular issue in *Kaiser* . . . ."[27] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[28] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[29]

2. The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"). Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[30] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to administrative appeals."[31] The court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

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[26] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).
[27] *Id.* at 75165.
[28] *Id.*
[29] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[30] *Id.* at 297 (citation omitted).
[31] *Saint Francis Med. Ctr. v. Azar,* 894 F.3d 290, 294 (D.C. Cir 2018) (emphasis added).

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. However, it is clear from the *Saint Francis* case that the D.C. Circuit interpreted the reopening regulation at 42 C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Moreover, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the interpretation of 42 C.F.R. § 405.1885 (as revised in 2013) because the Provider could bring suit in the D.C. Circuit.[32] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be re-determined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal*.

C. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulation (as described more fully below) and that the appeals of fiscal years involving predicate facts are governed by the D.C. Circuit's decisions in *Kaiser* and *Saint Francis.* In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[33] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Board's Analysis of the Appealed Issue

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 IRP residents (*i.e.*, 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 equation results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in

[32] 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).

[33] *See* 42 C.F.R. § 405.1837.

their request for EJR used to calculate the allowable count for residents (*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP resents and fellows) in nonprimary care programs:

$$\textbf{\textit{Allowable FTE count}} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times Weighted\ FTE\ Count$$ [34]

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.[35] 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.[36] 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 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

[34] Providers' EJR Request at 6; Providers' Response to RFI at 2.
[35] *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.)).
[36] 66 Fed. Reg. at 39894 (emphasis added).

> ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[37]

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.[38] 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."[39] 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[40] (*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.[41]

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:

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[37] (Emphasis added.)

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

[39] *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.)).

[40] 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.

[41] 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.

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

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 equation:

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

This equation 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.

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 those cases.

Board Members Participating:

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

FOR THE BOARD:

7/23/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Byron Lamprecht, WPS (Electronic Mail w/ Schedules of Providers)
Judith Cummings, CGS (Electronic Mail w/ Schedules of Providers)
Laurie Polston, NGS (Electronic Mail w/ Schedules of Providers)
Pam VanArsdale, NGS (Electronic Mail w/ Schedules of Providers)
Danene Hartley, NGS (Electronic Mail w/ Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/ Schedules of Providers)

Appendix I -- List of Cases

Filed May 14, 2019

18-0338GC Beaumont Health 2013 DGME Fellows Group
18-0337GC Beaumont Health 2013 DGME Prior and Penultimate Years Fellows Group
18-1058GC Beaumont Health 2014 DGME Fellows Group
18-1068GC Beaumont Health 2014 DGME Prior and Penultimate Years Fellows Group
17-1289GC Cleveland Clinic 2014 DGME Fellows Group
18-0022GC Cleveland Clinic 2014 DGME Prior and Penultimate Years Fellows Group
18-0567G K&S 2007-2010 Fellows Group
18-0705G K&S 2007-2010 DGME Prior and Penultimate Years Fellows Group
18-0506GC Mount Sinai Health System 2011 DGME Fellows Group
18-0502GC Mount Sinai Health System 2011 DGME Prior and Penultimate Years Fellows

Filed May 21, 2019

17-1685GC Cleveland Clinic 2015 DGME Fellows - Present Year CIRP Group
18-0224G K&S 2011-2013 DGME Fellows Group
18-0225G K&S 2011-2013 DGME Fellows Prior and Penultimate Years Group
18-0837GC Duke 2014 DGME Fellows CIRP Group
18-0838GC Duke 2014 DGME Fellows Prior and Penultimate Years CIRP Group
19-1770GC Cleveland Clinic Fdn. CY 2015 DGME Fellows - Prior & Penultimate Years Group
19-1901G King & Spalding CY 2012 DGME Fellow Penalty Prior and Penultimate Years (II)
19-1902G King & Spalding CY 2012 DGME Fellow Penalty Present Year Group
19-1903G King & Spalding CY 2011 DGME Fellow Penalty Prior and Penultimate Years (II) Group
19-1904G King & Spalding CY 2011 DGME Fellow Penalty Present Year (II) Group

Filed May 29, 2019

18-0226G K&S 2015 DGME Fellows Group
18-0227G K&S 2015 DGME Fellows Prior and Penultimate Years Group
18-0246G K & S 2014 DGME Fellows Group
18-0247G K & S 2014 DGME Fellows Prior and Penultimate Years Group
18-0806GC Carolinas HealthCare System 2013 DGME Fellows CIRP Group
18-0807GC Carolinas HealthCare System 2013 DGME Fellows Prior and Penultimate Years
19-1535G King & Spalding CY 2013 DGME Fellow Penalty Present Year (II) Group
19-1536G King & Spalding CY 2013 DGME Fellow Penalty Prior and Penultimate Years (II)
19-1948G King & Spalding CY 2015 DGME Fellow Penalty Present Year (II) Group
19-1949G King & Spalding CY 2015 DGME Fellow Penalty Prior and Penultimate Years (II)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Baylor Scott & White Health
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Novitas Solutions, Inc.
Justin Lattimore, Director
707 Grant St., Ste. 400
Pittsburgh, PA 15219

RE: Baylor Medical Center at Garland (Provider No. 45-0280)
FYE 12/31/2006
Case No. 16-2098

Dear Mr. Galinsky and Mr. Lattimore,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents from the above-referenced appeal and has set forth below its jurisdictional decision.

Background

Baylor Medical Center at Garland is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Correction of Program Reimbursement ("Revised NPR") dated January 26, 2016 for fiscal year end ("FYE") 12/31/2006. The Provider timely filed an appeal from the revised NPR on July 27, 2016. The Model Form A-Individual Appeal Request presented nine issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH—SSI Fraction/ Medicare Managed Care Part C Days
4. DSH—SSI Fraction/Dual Eligible Days
5. DSH—Medicaid Fraction/ Medicare Managed Care Part C Days
6. DSH—Medicaid Fraction/ Dual Eligible Days
7. DSH—Medicaid Eligible Days
8. DSH—Medicare Managed Part C Days
9. DSH—Dual Eligible Days

On March 8, 2017, the Board received requests to transfer the following issues to group appeals:

- Issue 2: DSH/SSI Systemic Errors to Case No. 17-1179GC
- Issue 3: SSI Fraction/ Medicare Managed Part C Days to Case No. 17-1180GC
- Issue 4: SSI Fraction/ Dual Eligible Days to Case No. 17-1182GC
- Issue 5 and 8: Medicaid Fraction/ Medicare Managed Part C Days to Case No. 17-1181GC
- Issues 6 and 9: Medicaid Fraction/Dual Eligible Days to Case No. 17-1183GC

The Medicare Contractor submitted a jurisdictional challenge over Issues 1 and 5 through 9.

Medicare Contractor's Contentions

The Medicare Contractor asserts that the Board does not have jurisdiction over the following issues: 1) SSI Provider Specific; 5) Medicaid Fraction/Medicare Managed Care Part C Days; 6) Medicaid Fraction/ Dual Eligible Days; 7) Medicaid Eligible Days; 8) Medicare Managed Care Part C Days; 9) Dual Eligible Days.[1]

The Medicare Contractor argues that Issue 1 (SSI Provider Specific) should be dismissed because it is duplicative of Issue 2 (SSI Percentage).[2] Furthermore, the Medicare Contractor contends that Issue 1 includes the Provider's subsidiary appeal over SSI realignment.[3] The Medicare Contractor asserts that SSI realignment is a hospital election.[4] Once the election is made, the hospital is bound by that decision, regardless of reimbursement impact.[5] Finally, the Provider's appeal is premature as there has been no final determination.[6]

The Medicare Contractor contends that the revisions cited by the Provider as sources of dissatisfaction (Adjustments Nos. 4, 5, 7, and 8) ". . . deal solely with updating the SSI percentage in various parts of the cost report," and that "[n]one of the adjustments render a final determination with respect to the Medicaid ratio issues."[7]

With regard to Issue 8 (Medicare Managed Part C Days), the Medicare Contractor argues that it is duplicative of the problems addressed by the Provider in Issues 3 and 5.[8] Similarly, the Medicare Contractor contends that Issue 9 (Dual Eligible Days) is duplicative of Issues 4 and 6.

Provider's Contentions

SSI Provider Specific

The Provider contends that the Issue 1 (Provider Specific) and Issue 2 (SSI Systemic Errors) are not duplicative because they address "separate and distinct" issues.[9] The Provider cites Board Rule 8.1 as support of its argument that Issues 1 and 2 represent different components of the SSI issue, meaning that they are not duplicative.[10] The Provider states that Issue 2 ". . . addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008)

[1] Medicare Contractor's Jurisdictional Challenge at 1.
[2] *Id*.
[3] *Id*. at 2.
[4] *Id*.
[5] *Id*.
[6] *Id*.
[7] *Id*. at 3.
[8] *Id. at 5.*
[9] Provider's Jurisdictional Response at 1.
[10] "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible. . . ." Board Rule 8.1.

in CMS' calculation of the disproportionate payment percentage . . .", while Issue addresses ". . . various errors of omission that do not fit into the "systemic errors" category.[11]

In addition, the Provider contends that ". . . this is an appealable item because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2006, resulting from its understated SSI percentage due to errors and omissions."[12] In support of its assertion, the Provider cites *Northwest Hosp. Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011) where the Centers for Medicare and Medicaid Services ("CMS") ". . . specifically abandoned the CMS Administrator's December 1, 2008 decision that the SSI ratio cannot be revised based upon data after it has been calculated by CMS."[13]

Medicaid Eligible Days

The Provider argues that there was an adjustment made to the Provider's DSH (Audit Adjustment No. 5) and that this adjustment was enough to warrant Board jurisdiction over this appeal issue.[14] Further, the Provider states ". . . that an adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report.[15]

Consolidation of Duplicate Issues

The Provider agrees with the Medicare Contractor's assertion that some of the issues were duplicative. Subsequently, the Provider requested the consolidation of Issue 5 (DSH—Medicare Fraction/Medicare Managed Care Part C Days) with Issue 8 (DSH—Medicare Managed Care Part C Days), as well as the consolidation of Issue 6 (DSH—Medicaid Fraction/Dual Eligible Days) with Issue 9 (DSH—Dual Eligible Days).[16]

Board's Decision

As set forth below, the Board finds that it does not have jurisdiction over the following two issues which were not subject to a transfer request and which remain pending in this appeal –the SSI Provider Specific issue and Medicaid Eligible Days issue.

SSI Provider Specific

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant components: 1) the Provider disagreed with the Medicare Contractor's computation of the SSI percentage that would be used to determine

[11] *Id*. at 2.
[12] *Id*.
[13] *Id*.
[14] *Id*. at 3.
[15] *Id*.
[16] *Id*. at 8.

the DSH percentage, and 2) the Provider reserving the right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The Provider's disagreement with the Medicare Contractor's computation of SSI percentage is duplicative of the Systemic Errors issue that the Provider requested transfer to Case No. 17-1179GC (QRS BSWH 2006 DSH SSI Percentage CIRP Group). The Provider's DSH payment (Provider Specific) issue questions "[w]hether the Medicare Administrative Contractor ('MAC') used the correct Supplemental Security Income ('SSI') in the Disproportionate Share Hospital ('DSH') calculation." [17] The Provider explains the legal basis for this issue as follows: ". . . its SSI percentage published by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation," and that ". . . the SSI percentage issued by CMS is flawed."[18] The Provider similarly explains the legal basis for the SSI Systemic Errors Issue as follows: ". . . the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed," and ". . . the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008).[19] Essentially, the Provider is simply arguing that its SSI percentage is inaccurate, which makes this issue duplicative of Issue 1 in the instant case. Accordingly, the Board hereby dismisses this aspect of the SSI Percentage issue because it is duplicative of the Systemic Errors issue for which there is a transfer request.

The second component of Provider Specific Issue (the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period) is dismissed by the Board due to a lack of jurisdiction. Pursuant to 42 C.F.R. § 412.106(b)(3), when determining a Provider's DSH percentage, "[i]f a prefers that CMS, through its intermediary, a written request. . . ." Without the written request, the Medicare Contractor cannot issue a final determination that the Provider can use to prove dissatisfaction during an appeal as required by 42 C.F.R. § 405.1835(a)(1). As the Provider had no final determination from which to appeal this issue when the Provider filed its appeal with the Board, the Board finds that it lacks jurisdiction over this remaining aspect of the Provider Specific Issue and hereby dismisses it.

Medicaid Eligible Days

The Board finds that it does not have jurisdiction over this issue as there was no adjustment made to Medicaid Eligible Days on the Provider's revised NPR.

In certain instances, there is an opportunity for a determination to be reopened (e.g., a Medicare contractor may reopen an NPR and issue a revised NPR). In this regard, 42 C.F.R. § 405.1885 (2015) states:

[17] Provider's Individual Appeal Request Tab 3, Issue 1
[18] *Id*.
[19] Provider's Individual Appeal Request Tab 3, Issue 2.

> (a) *General*. A secretary determination, a contractor determination, or a decision by a reviewing entity (as described in § 405.1801(a)) may be reopened, with respect to specific finding s on matters at issue in a determination or decision, by CMS (with respect to Secretary determinations), by the contractor (with respect to the contractor determinations), or by the reviewing entity that made the decision (as described in paragraph (c) of this section).

42 C.F.R. § 405.1889 further explains the circumstances under which revised determinations are appealable:

> (a) If a revision is made in a Secretary of 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, 405.1975, 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.
>
> (b)(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.

In accordance with these regulations, a Provider can only appeal items that were specifically adjusted in the revised cost report. Here, the Medicaid Eligible Days were not adjusted on the Provider's revised cost report. Rather, the primary adjustments were made to correct mathematical errors, update the SSI ratio, and zero out the cost report in preparation for reopening. In the April 15, 2011 Notice for Reopening of Cost Report issued to the Provider, CMS stated that it was reopening the cost report in order "[t]o revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of the Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS." As the revised NPR is a distinct determination and no adjustments were made to the Medicaid Eligible Days, the Board finds that it does not have jurisdiction over this issue and hereby dismisses it.

Consolidation of Duplicate Issues

The Board finds that the Provider appealed duplicate issues and grants consolidation of those issues as follows:

1. The Board hereby consolidates Issue 8 (DSH—Medicare Managed Care Part C Days) with Issue 5 (Medicaid Fraction/Medicare Manages Care Part C Days) for which the Provider requested transfer to Case No. 17-1181GC.

2. The Board hereby consolidates Issue 9 (DSH – Dual Eligible Days) with Issue 6 (DSH—Medicaid Fraction/Dual Eligible Days), for which the Provider requested transfer to Case No. 17-1183GC.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative off the SSI Systemic Errors issue transferred to a group and because there is no final determination with respect to the realignment portion of the issue statement.

The Board also finds that it does not have jurisdiction over the Medicaid Eligible Days issue as there was no specific adjustment made to the Medicaid Eligible Days in the Provider's revised NPR.

As no issues remain pending in this appeal, Case No. 16-2098 is hereby closed and removed from the Board's docket.

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

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For the Board:

7/24/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Merit Health Central (Provider No. 25-0072)
FYE 09/30/2014
Case No. 17-1488

Dear Messrs. Summar and Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in case number 17-1488. The jurisdictional decision of the Board is set forth below.

Background

Merit Health Central is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement ("NPR") dated November 17, 2016 for FYE 09/30/2014. The Provider timely filed an appeal from the NPR on May 11, 2017. The Model Form A - Individual Appeal Request presented eleven issues:

1. DSH/Supplemental Security Income Percentage ("SSI") (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH—SSI Fraction/Medicare Managed Care Part C Days
4. DSH—SSI Fraction/Dual Eligible Days
5. DSH— Medicaid Fraction/Medicare Managed Care Part C Days
6. DSH—Medicaid Fraction/Dual Eligible Days
7. DSH—Medicaid Eligible Days
8. DSH—Medicare Managed Care Part C Days
9. DSH — Dual Eligible Days
10. Uncompensated Care Distribution Pool ("UCC")
11. 2 Midnight Census IPPS Payment Reduction

On January 26, 2018 the Provider submitted its Preliminary Position Paper and indicated that all issues except the SSI Provider Specific and Medicaid Eligible Days were being transferred to various group appeals, including the SSI Systemic Errors issue to Case No. 17-0578GC (QRS HMA 2014 DSH SSI Percentage CIRP Group).

On May 21, 2018 the Board received the Medicare Contractor's Preliminary Position Paper and the Medicare Contractor's Jurisdictional Challenge on April 4, 2018. The Board received the Provider's response to Medicare Contractor's Jurisdictional Challenge on May 1, 2018.

Medicare Contractor Contentions:

The Medicare Contractor has challenged jurisdiction over six issues: SSI Part A Percentage Realignment, Medicaid Eligible days, Medicare Managed Care Part C days and Dual Eligible days; Duplicate Issues include the SSI Provider Specific, SSI Systemic Errors Issue and the UCC issue.

A. SSI Provider Specific

The Medicare Contractor contends that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue. Further, the Medicare Contractor argues that the issue is suitable for reopening, but it is not an appealable issue.[1] The Medicare Contractor supports its contention of reopening in the context of an SSI realignment request, for which it has not made a final determination with which a Provider could be dissatisfied. Therefore, the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. The Medicare Contractor concludes that the Provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by including the realignment as an appeal issue.[2]

B. Medicaid Eligible Days

The Medicare Contractor asserts that Adjustments Nos. 6, 16, 17 and 19 for which the Provider cited as a source of dissatisfaction, do not render a final determination with respect to additional Medicaid Eligible days.[3] Adjustment No. 16 updated the SSI ratio and Adjustment Nos. 16 and 17 updated Worksheet S-3, Part 1 to reflect the Providers PS&R. The Provider references Adjustment No. 19 which removed protested amounts; however, eligible days were not contested on the protest worksheet.[4]

[1] Medicare Contractor's Jurisdictional Challenge at 4.
[2] *Id.* at 5.
[3] *Id.* at 6.
[4] *Id.* at 6-10.

C. Medicare Managed Care Part C Days and Dual Eligible Days

The Medicare Contractor argues that the Provider has already bifurcated the Medicare Managed Care Part C Days issue into two separate and distinct issues – Medicare Managed Care Part C Days within the SSI Fraction and Medicare Managed Care Part C days within the Medicaid Fraction.[5] The Medicare Contractor concludes that these fractions added together and expressed as the DSH percentage and that, therefore, the Provider's inclusion of the general Medicare Managed Care Part C Days issue is redundant in this case.[6]

Similarly, the Medicare Contractor again contends that the Provider already bifurcated the Dual-Eligible Days issue into two separate and distinct issues – Dual-Eligible within the SSI Fraction and Dual-Eligible days within the Medicaid Fraction.[7] Therefore, the Medicare Contractor argues that these fractions added together and expressed as the DSH percentage and that, therefore, the Provider's inclusion of the general Dual Eligible Days issue is also redundant in this case.[8]

D. Uncompensated Care

The Medicare Contractor challenged jurisdiction over the UCC issue. However, that issue was transferred to a group appeal on January 30, 2018 (Case No. 17-0573GC). As such, the Board will not address the challenge in this individual appeal.

Provider's Contentions:

A. SSI Provider Specific

The Provider contends that the Medicare Contractor is incorrect in asserting that the DSH/SSI realignment issue is not an appealable issue.[9] The Provider states that it is addressing the realignment of the SSI percentage, but also "various errors of omission and commission" that do not fit into the "systemic errors" category.[10] Thus, the Provider argues that this is an appealable issue because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments it received for fiscal year end ("FYE") as a result of its understated SSI percentage.[11]

[5] *Id*. at 11.
[6] *Id.*
[7] *Id*. at 12.
[8] *Id.*
[9] Provider's Jurisdictional Response at 2.
[10] *Id.*
[11] *Id.*

Further, the Provider argues that in *Northeast Hosp. Corp. v. Sebelius*,[12] the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision.[13] The decision that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.[14] Consequently, the Provider reasons that it can submit data to prove its SSI percentage was understated.

B. Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over the Medicaid Eligible Days issue because there was an adjustment to the DSH on its cost report, which is sufficient to warrant jurisdiction and that DSH need not be adjusted or claimed on a cost report.[15]

C. Medicare Part C and Dual Eligible Days Duplicate Issues

The Provider agrees that there are duplicate issues and requests that Issue 5 be consolidated with Issue 8 and that Issue 6 be consolidated with Issue 9.[16]

Board's Decision

A. SSI Provider Specific Issue

As set forth below, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue.

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This issue is duplicative of the SSI Systemic Errors issue that was transferred to Case No. 17-0578GC. The Providers in that CIRP group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation. Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider Specific issue.

[12] 657 F.3d 1 (D.C. Cir. 2011).
[13] *Id.*
[14] *Id.*
[15] *Id*. at 3.
[16] *Id*. at 13.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request . . . ." Without a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue statement and hereby dismisses this remaining aspect of the SSI Provider Specific issue.

B. Medicaid Eligible Days

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

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. Regulation dictates that a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy…

However, subsequent developments have modified how this regulation is applied.

In *Banner Heart Hospital v. Burwell* ("*Banner*"),[17] the D.C. District Court held that a Provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1)

[17] 201 F. Supp. 3d 131 (D.D.C. 2016).

when the Provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy).[18] The D.C. District Court looked to the Supreme Court's decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[19] which also addressed a challenge to a regulation which was not first presented to the Medicare contractor.[20] *Bethesda* held that a Provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[21]

Following the *Banner* decision, CMS issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to largely follow the holding in *Banner*. Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed, but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item, if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[22]

The first step of analysis under Ruling 1727 is related to the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on May 11, 2017 and the appeal was open on April 23, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end September 30, 2014 cost report and, therefore, the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other 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."[23]

Under §§ 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a Provider, unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—the Secretary's regulation at 42 C.F.R. § 412.106(b)(4)(iii) (2010) mandates that a DSH-eligible hospital "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed…and of

[18] 42 C.F.R. 405.1835(a)(1)(2013).
[19] 485 U.S. 399 (1988).
[20] *Banner* at 141.
[21] *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) at 404.
[22] Ruling 1727 at unnumbered page 2.
[23] Ruling 1727 at 6.

verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day."[24] In this case, the Provider maintains that the Medicaid eligible days at issue could not be reported on the as-filed cost report because information needed from the State for verification of those days by the State was not available prior to the cost reporting deadline.[25] As § 412.106(b)(4)(iii) requires hospitals to claim (and otherwise binds Medicare contractors to accept) only State-verified Medicaid eligible days on the cost report and the Provider has established that a practical impediment, through no fault of its own, prevented it from identifying and/or verifying with the relevant State the Medicaid eligible days at issue prior to filing of the cost reports at issue.[26] Accordingly, as DSH regulations instruct, a Provider is required to furnish Medicaid patient verification information to the Medicare Contractor and due to the time frame within which a hospital must file its cost report, per regulation, the Board finds that the Provider's DSH Medicaid Eligible Days issue "was subject to a regulation or other 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."

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a Provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[27] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, the DSH Medicaid Eligible Days sought are *not* within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider's cost report, as required by regulation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii)) as applicable, if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor is bound by the proof of eligibility regulation at 42 C.F.R. §

[24] *See also* CMS Ruling 97-2.
[25] *See* Provider Jurisdictional Response at 6 (May 1, 2018).
[26] A thorough discussion of providers' obligation to claim State-verified Medicaid eligible days on the cost report is included in the following Board decisions: *Norwalk Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No. 2012-D14, (Mar. 19, 2012), *vacated*, CMS Adm'r Dec. (May 21, 2012); *Danbury Hosp. v. Blue Cross and Blue Shield Ass'n*, PRRB Dec. No.2014-D03 (Feb. 11, 2014), *declined review*, CMS Adm'r (Mar. 26, 2014); *Barberton Citizen* 9, 2015), *declined review*, CMS Adm'r (Apr. 29, 2015).
[27] 42 C.F.R. § 405.1835(a) (2010).

412.106(b)(4)(iii), and it is recommended that the Board "not apply the self-disallowance jurisdiction regulation" in its jurisdictional decision.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however the Provider did not self-disallow the DSH Medicaid Eligible Days issue and, therefore, this step is not applicable to this appeal.

Notwithstanding the lack of evidence and argument put forth by the Provider, the Board finds that the DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification. Therefore, only DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to both parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

C. Medicare Part C and Dual Eligible Days Duplicate Issues

The Board agrees with the parties that Issue 8, Medicare Managed Care Part C Days, and Issue 9, Dual Eligible Days, are duplicative of the same issues that the Provider separately appealed for the Medicaid and SSI Fractions, and that have since been transferred to group appeals. Therefore, the Board hereby consolidates the Medicare Managed Care Days issue with Medicaid and SSI fraction issues that were transferred to Case Nos. 17-0574GC and 17-0576GC, respectively. Similarly, the Board hereby consolidates the Dual Eligible Days issue with the Medicaid and SSI fraction issues that were transferred to Case Nos. 17-0577GC and 17-0575GC, respectively. The Medicare Managed Care Part C Days and Dual Eligible Days issues are no longer pending in this individual appeal.

D. Uncompensated Care

While the Medicare Contractor challenged jurisdiction over the UCC issue, the Provider filed a transfer request with the Board to transfer that issue to a group appeal on January 30, 2018 (Case No. 17-0573GC). As such, the Board will not address the challenge in this individual appeal.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue.

The Board finds that it has jurisdiction over the Medicaid Eligible Days issue based on CMS Ruling 1727-R.

The Board consolidates Issues five and eight (Medicare Managed Care) and Issues six and nine (Dual eligible days) as they are duplicative. These issues were transferred to CN's 17-0574GC and 17-0577GC.

The UCC Distribution Pool issue was transferred to a group appeal, so that challenge will not be addressed at this time.

As the Medicaid Eligible Days issue remains pending, Case No. 17-0057 will remain open and the Board will schedule it for hearing.

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

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7/24/2019

X Clayton J. Nix

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Board Chair
Signed by: Clayton J. Nix -A

cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Ronald S. Connelly, Esq.
Powers, Pyles, Sutter & Verville
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RE: ***EJR Determination***
Powers Pyles 2011-2014 GME Solutions DGME Fellowship Penalty Group
Case No. 18-1241G

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 27, 2019 request for expedited judicial review ("EJR") received June 28, 2019. The decision of the Board is set forth below.

The issue under appeal in this case is:

> Whether the Medicare Contractor ("MAC") must correct its determination of the Providers' cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME"). [The Providers assert that] . . . 42 C.F.R. § 413.79(c)(2) implementing the cap and weighting factors, is contrary to the statute because it imposes on the Providers a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents Providers from claiming FTEs up to their full caps. [The Providers contend that] 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Providers' DGME payments consistent with the statute so that the DGME caps are set at the number of FTE residents that each Provider trained in its most recent cost reporting periods ending or before December 31, 1996, and residents beyond the IRP are weighted at no more than 0.5.[1]

[1] Providers' May 1, 2018 Hearing Request, Tab 2.

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:

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 "resident 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.

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[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).
[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).

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 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

[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (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).

> 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. . . .
>
> 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*

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *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:
>
> > (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 ("FY 2005 IPPS Final Rule"), 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.

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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.

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] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

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:

> [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.

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[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.")
[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).

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(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 ("WCap") is determined for the current year that is based on the weighted FTE count for the current year ("WFTE") multiplied by the ratio of the 1996 unweighted FTE count ("UCap") to the current year unweighted FTE count ("UFTE"). The resulting equation, WFTE(UCap/UFTE) = WCap,[23] 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 12 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)(ii)-(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. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of

[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.
[24] 42 U.S.C. §1395(h)(4)(F)(i).

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 Hosp. Ass'n v. Bowen* ("*Bethesda*").[25] 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.[26]

On August 21, 2008, new regulations governing the Board were effective.[27] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[28] 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 D.C. 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.[29]

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

B. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulation, as described more fully below. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The appeals were timely filed.

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[25] 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.).
[26] *Bethesda*, 108 S. Ct. at 1258-59.
[27] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016).
[29] *Id.* at 142.
[30] *See* 42 C.F.R. § 405.1837.

Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying participants. 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 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 IRP residents (*i.e.*, 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 equation 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 residents (*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP residents and fellows) in nonprimary care programs:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [31]

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.[32] 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.[33] 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

[31] Providers' EJR Request at 4.
[32] *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.)).
[33] 66 Fed. Reg. at 39894 (emphasis added).

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].[34]

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.[35] 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."[36] 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[37] (*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.[38]

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[34] (Emphasis added.)

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

[36] *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.)).

[37] 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.

[38] 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

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 equation:

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

This equation 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).[39] 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.

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.

[39] The Board recognizes that the Providers' EJR request refers to both subparagraphs (ii) and (iii) of 42 C.F.R. § 413.79(c)(2). However, the fiscal years at issue for the Providers in this group appeal range from 2011 to 2015. As such, the portion of 42 C.F.R. § 413.79(c)(2) that is applicable to this case (*i.e.*, the portion of the regulation that contains the equation at issue *that was applied to the Providers in this group appeal*) is 42 C.F.R. § 413.79(c)(2)(iii). In this regard, the Board notes that, while 42 C.F.R. § 413.79(c)(2)(ii) also contains the same equation, it is not applicable to the Providers in this group appeal because it only covers "a cost reporting period beginning on or after October 1, 1997, and before October 1, 2001" as a result of the FY 2002 IPPS Final Rule (as well as the regulation restructuring and relocation occurring as part of the FY 2005 Final Rule).

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participants in this appeal 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 this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

7/26/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Pamela Fowler
Maricopa Medical Center
2601 E Roosevelt St.
Phoenix, AZ 85008

John Bloom
Noridian Healthcare Solutions
P.O. Box 6722
Fargo, ND 58108

RE: ***Untimely Filing – Reinstatement Request Denied***
Maricopa Medical Center (Provider No. 03-0022, FYE 06/30/2009)
Case No. 14-1121

Dear Ms. Fowler and Mr. Bloom:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to your June 20, 2019, request for reinstatement ("Reinstatement Request") of Maricopa Medical Center's ("Maricopa") case. The Board is denying your request for reinstatement of this case for the reasons set forth below.

Pertinent Facts:

The Board established this case on November 29, 2013 when the Board received *via USPS Priority Mail* Maricopa's Individual Appeal Request for fiscal year ending June 30, 2009. In its appeal, the Provider includes a number of issues related to its Notice of Program Reimbursement ("NPR") issued in May 30, 2013. Per the appeal request, Maricopa designated Randy Graham, the Director of Reimbursement for Maricopa, as its representative and gave the contact information (including email address) for Mr. Graham.

On December 21, 2013, the Board sent via email to Maricopa's designated representative, Mr. Graham, the Acknowledgement and Critical Due Dates that included instructions for Maricopa to submit a preliminary position paper ("PPP") by September 1, 2014. On August 29, 2014, Mr. Graham sent Maricopa's PPP *via certified USPS.*

On April 30, 2018, the Board emailed the Notice of Hearing to the Maricopa's designated representative, Mr. Graham. The Notice of Hearing included instructions for Maricopa to submit a final position paper ("FPP") by September 1, 2018. On September 26, 2018, the Board dismissed the appeal based on Maricopa's failure to file its FPP.

Discussion:

Prior to the issuance of the Notice of Hearing, the Provider asserts that it "had submitted correspondence via U.S. Mail to [the Board] requesting that the case representative for ***all*** *open individual appeal issues* be updated to Kathy Benaquista, Chief Financial Officer."[1] This correspondence is dated June 1, 2017. The Provider also asserts that it emailed copies of this correspondence to Noridian Administrative Services and Federal Specialized Services for multiple fiscal years. Specifically, the 2017 Letter includes the case number for the six cases in the "regarding" or "RE" line and states the following in the body of the letter:

> Randy Graham, Director of Reimbursement, previously represented Maricopa Medical Center on appeals for the years outlined above. *As Mr. Graham is no longer employed by Maricopa Medical Center, Toyon Associates is hereby authorized to represent it* ***with respect to Medicare group appeals*** for FYEs 6/30/2008 through 6/30/2011 and 6/30/2013 through 6/30/2014. Any correspondence regarding group appeals should be sent to:
>
> > [Provided contact information for Dylan Chinea at Toyon Associates]
>
> Any correspondence regarding all other appeals should be sent to:
>
> > [Provided contact information for Kathy Benaquista, Chief Financial Officer for Maricopa].[2]

Significantly, while Maricopa asserts that it mailed to the Board the Change in Representative letter dated the June 1, 2017 (the "2017 Letter"), the Board has no record of it receiving this letter. In this regard, the Board notes that the 2017 Letter states that it is to be applied to six (6) specific cases (including Case No. 14-1121). However, upon the Board's review of all six of the files for those cases, the Board did not find the letter present in any of those case files and did not find any indication in any of those case files that the Board had otherwise received it.

On May 30, 2019, the Board received *via FedEx* a nearly identical letter to the 2017 Letter that was filed in the six cases previously referenced.[3] The May 30, 2019 letter stated that the previous representative (*i.e.*, Randy Graham, Director of Reimbursement) was no longer employed by Maricopa and that the new Director of Reimbursement, Pamela Fowler is the authorized representative for these cases:

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[1] Provider's Request for Reinstatement at 1 (June 20, 2019).
[2] *See* Provider's Request for Reinstatement, Attachment 1 (Letter Dated June 1, 2017, indicating reference to Case Nos.: 13-3473, 14-1121, 14-3150, 15-0629, 16-1140, and 17-0097).
[3] *See* Provider's Request to Change Designated Case Representative (filed May 30, 2019).

> Randy Graham, Director of Reimbursement, previously represented Maricopa Medical Center on appeals for the years outlined above. *As Mr. Graham is no longer employed by Maricopa Medical Center,* Pamela Fouler is herby authorized to represent the provider with respect to the individual Medicare appeal case numbers 13-3473, 14-1121, 14-3150, 15-0629, 16-1140 and 17-0097
>
> Any correspondence regarding these appeals should be sent to:
>
> > [Provided contact information Pamela Fowler, Director of Reimbursement for Maricopa].

Significantly, the May 30, 2109 letter did not refer to the 2017 Letter or to either Toyon Associates ("Toyon") or Maricopa's CFO, Kathy Benaquista.

Given that the Board did not receive the 2017 Letter, the Board electronically transmitted the April 30, 2018 Notice of Hearing to the representative on record, Mr. Graham. Similarly, when the FFP was not filed by the September 1, 2018 deadline, the Board issued its September 26, 2018 dismissal letter to the representative on record, Mr. Graham.

Maricopa maintains that Mr. Graham was not the correct representative per the 2017 Letter and that it did not learn until earlier this year that this case had been dismissed. Maricopa notes that only two issues remain, and that Maricopa and Medicare Contactor had previously come to an agreement to resolve these issues as addressed within the respective preliminary position papers.

Board's Determination

As set forth below, the Board finds that it properly dismissed this case in 2018 for Maricopa's failure to timely file a final position paper. Pursuant to 42 C.F.R. § 405.1868:

> The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provision of section 1878 of the Act and of the regulations . . . . The Board's powers include the authority to take appropriate actions in respond to the failure of a party to a Board appeal to comply with Board rules and orders . . . .
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice . . .

Board Rules also support dismissal of the referenced appeal. Board Rule 27.1 (July 2015) states that "[t]he Board will set due dates for the final position papers in its Notice of Hearing" and, consistent with that Rule, the Notice of Hearing for this case set the deadline for Maricopa's FPP as September 1, 2018.[4] Finally, Board Rule 46.3 (July 2015) addresses dismissals for failure to comply with Board procedures:

> **46.3 – Dismissals for Failure to Comply with Board Procedures**
>
> Upon written motion demonstrating good cause, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, *administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion. [*July 1, 2015*]

Maricopa claims that it initially sent the 2017 Letter to change its representative of record to the Board via U.S. mail and to the Medicare Contractor and FSS via email. However, as discussed above, the Board has reviewed its records and finds that it did not receive the 2017 Letter. In fact, the first letter that the Board received to change the representative of record in this case was received on May 30, 2019, roughly 8 months after the Board had dismissed Case No. 14-1121. Indeed, the May 30, 2019 letter does not refer to the June 2017 Letter (or even Ms. Benaquista) and suggests that Mr. Graham, original representative, was still then the representative of record.

As noted above, Board Rule 47.3 states that administrative oversight, settlement negotiations, or a change in representative generally will not be considered good cause to reinstate.[5] It further states that, if the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion.[6] Maricopa included its missing Final Position Paper with its Motion for Reinstatement, and noted that all but two issues have been withdrawn and that Maricopa and Medicare Contactor had previously come to an agreement to resolve the remaining two issues via an administrative resolution.

The Board finds it properly dismissed the appeal on September 28, 2018, for Maricopa's failure to file its Final Position Paper and denies Maricopa's request for reinstatement. While Maricopa claims that it drafted and sent the Board a request to change in the representative in this case, *i.e.*, the 2017 Letter, the Board has no record of receipt of that letter and must find that it properly

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[4] Right before Maricopa's September 1, 2018 FPP filing deadline, the Board issued a new set of Board Rules on August 28, 2018 that confirmed in Board Rule 27.1 that "[f]or appeals filed prior to the effective date of the rules, the final position paper remains a required filing, and failure to timely file the final position papers may result in dismissal of the case, or any of the actions under 42 C.F.R. § 405.1868."
[5] Board Rule 47.3.
[6] *Id*.

sent the Notice of Hearing (and dismissal) to the representative of record. The Board Rules are clear, a provider must *promptly* update the contact information at the Board:

> **Rule 5 – Provider Case Representative**
>
> **5.1 – Persons**
>
> The case representative is the individual with whom the Board maintains contact. . . .
>
> *The contact information for the case representative that is on file with the Board must be current with the Board at all times*. As the *Board sends much of its correspondence electronically, maintaining a current e-mail address on file with the Board is a responsibility of the case representative* (*see* Rule 5.2) *and is imperative to ensure that the case representative receives Board correspondence. [March 2013]*
>
> **5.2 – Responsibilities**
>
> *The representative is responsible for informing the Board of changes in his or her contact information,* for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party. All actions by the representative are considered to be those of the Provider (But see Model Form D certification that Provider has been notified on transferring an issue to a group appeal). *Failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines*.
>
> **5.3 – Communications with Providers**
>
> *The Board will address notices to the Provider only to its official case representative. . . .*
>
> **5.4 – Designation of Representative Letter**
>
> The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. The letter must reflect the Provider's fiscal year under appeal and must also contain the following contact information: name, organization, address, telephone number, fax number and e-mail address of the representative. *[March 2013]*

> **5.5 – Withdrawal of Representation**
>
> **A. Deadlines Must Continue to be Met**
>
> Withdrawal of a case representative, or the recent appointment of a new representative, generally will <u>not</u> be *considered cause for delay of any deadlines or proceedings*.[7]

However, the Board received no such "change in representative" notice in compliance with Board Rules in any of the six cases noted in the 2017 Letter and a change in representative cannot itself be considered good cause for missing a filing deadline.[8]

Moreover, the Board notes that the content of the 2017 Letter focuses on Toyon as being "authorized to represent" Maricopa in ***group*** appeals and suggests that Maricopa may have written the letter for Toyon to use and attach in the context of ***group*** appeals (*i.e.*, that it may have been treated as an open letter that was not sent to the Board directly). Indeed, this is what appears to have happened. In this regard, the Board notes that, in support of its assertion that the 2017 Letter was sent to the Board, Maricopa attached to its June 20, 2019 request for reinstatement copies of three different group appeal requests that Toyon *filed on June 1, 2017* that included as an attachment to the appeal request a copy of the 2017 Letter to confirm that Toyon was the authorized representative for the *group* appeal request filings.[9]

Significantly, these Toyon group appeal request filings are dated ***the exact same date*** as the 2017 letter – June 1, 2017. This again reinforces the likelihood that the 2017 Letter was only used as an open letter attached to group appeal requests filed by Toyon. Similarly, if the 2017 Letter was in fact a request to change the representative for 6 individual cases then the May 30, 2019 letter requesting to change representatives should have referenced the 2017 Letter and/or referenced Ms. Benaquista, Chief Financial Officer for Maricopa, as the current representative. However, the May 30, 2019 letter refers to the original representative, Mr. Graham, without mentioning Ms. Benaquista.

Finally, the fact that the Board may have received the 2017 Letter as an attachment to a group appeal request has no bearing in the Board's review of the reinstatement request in this case. With a docket of approximately 10,000 cases, the Board does not (and cannot realistically be expected to) review representation letters that are attached to group appeal requests to see if they should be applied to other appeals pending before the Board.[10] It is the representative's responsibility to manage its cases per Board Rule 5.

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[7] Effective July 2015 (italics and underline emphasis added).

[8] It is unclear when Maricopa should have notified the Board of the change in representation because Maricopa does not give any information on when Mr. Graham left Maricopa in either the 2017 letter, the 2019 letter, or the 2019 request for reinstatement.

[9] The Board reviewed the case files for those 3 group appeals and did not find a copy of the 2017 letter received by the Board as a *stand-alone* document (*i.e.*, not as an attachment to an appeal request). This again confirms that the letter was not sent to the Board as an individual document.

[10] The facts of this case illustrate, in part, why the Board cannot and should not review attachments to filings to see if they should be placed in other files. In the context of the 2017 Letter *as an attachment to a group appeal*, the

As there is no evidence that the Board received the 2017 Letter as a stand-alone document, the Board must conclude that it was never sent to the Board as a stand-alone document. Based on the record, this appears to be a situation of administrative oversight on the part of Maricopa and no good cause for the untimely FPP filing has been demonstrated.[11] In the regard, Board Rule 46.3 is clear that "administrative oversight, settlement negotiations or a change in representative will not be considered good cause to reinstate" when a case is dismissed for failure to comply with Board procedures. The Board has approximately 10,000 appeals, and must be able to manage its docket effectively and efficiently. For those reasons, and those above, the Board hereby denies the Motion to Reinstate.

Board Members Participating:

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

For the Board:

7/29/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

content of the 2017 Letter is misleading and could lead the reader to believe that Maricopa had already taken action to change the authorized representative in those six individual cases because: (1) it states in the opening line that Mr. Graham "***previously*** *represented* [Maricopa] on appeals for the years outlined above" (emphasis added); and (2) unlike the May 30, 2019 letter, it does not include a clear request to change the designated representative on the six *individual* cases.

[11] In this regard, the Board also notes that the Provider allegedly learned of the late filing on May 9, 2019 but did not send a request for reinstatement until 42 days later on June 20, 2019. Maricopa did not include an explanation for this delay in its request for reinstatement.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway, Ste. 620
Plano, TX 75093-8724

RE: ***EJR Determination***
Southwest Consulting Summit Health 2012 DSH Medicaid Fraction Part C Days Grp.
Case No. 15-0026GC

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 2, 2019 request for expedited judicial review ("EJR") (received July 8, 2019) for the appeal referenced above.[1] The Board's determination regarding EJR is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] This EJR request also included Case Nos. 14-0348GC, 14-0356GC and 15-0025GC. Southwest Consulting (SWC) was advised that they were *not* the representative of record in Case Nos. 14-0348GC and 14-0356GC and, in response, SWC withdrew the July 8, 2019 EJR request for these two cases. By letter dated July 12, 2019, the Board advised SWC that it would take no action on the EJR request for these two cases. Similarly, the Board closed Case No. 15-0025GC on December 18, 2015. As a result, the Board notified SWC on July 9, 2019 that, as Case No. 15-0025GC is not pending before the Board, the EJR request for that case is not valid and, accordingly, the Board would not issue a decision on it.

[2] Providers' EJR Request at 4.

prospective payment system ("PPS").[3] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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

[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*
[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

> consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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].[15]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH

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[16] *Id.*
[17] 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.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[20] 69 Fed. Reg. at 49099.

> 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.[21]

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] 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.[26] However, the Secretary has not acquiesced to that decision.

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] 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*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-

[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.

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 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 involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the

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[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.).
[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.

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

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2012 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[38] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/30/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Bruce Snyder, Novitas (Electronic Mail w/Schedule of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedule of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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Hall Render Killian Heath & Lyman
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RE: ***EJR Determination***
Hall Render FFY 2019 Off-Campus Outpatient Site Neutral Payment Groups
Case Nos.: 19-1659GC, *et al*. (*see* attached Exhibit P-1 for a list of cases)

Dear Ms. Elias:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 28, 2019 request for expedited judicial review ("EJR") (received July 1, 2019). The decision of the Board is set forth below.

Issue

The issue under appeal in these cases is a:

> [C]hallenge [to] the implementation of a "site neutral" payment cut in the Medicare Outpatient Prospective Payment System [OPPS] for calendar year ("CY") 2019 for the "grandfathered" off campus provider-based departments ("PBD") that were billing as provider-based prior to November 2, 2015.

Background

All of the providers participating in the groups covered by this EJR (as listed in the attached Exhibit P-1) appealed from the CY 2019 outpatient prospective payment system ("OPPS") final rule published on November 21, 2018 ("CY 2019 Final Rule").[1] To put the above issue in the proper context, it is necessary to provide some background on how Medicare payment of hospital services evolved and how the OPPS itself was developed.

When the Medicare program was first implemented, it paid for hospital services (both inpatient and outpatient services) based on the hospital-specific reasonable costs attributable to furnishing services to Medicare beneficiaries. In 1983, the Medicare program began paying for most

[1] 83 Fed. Reg. 58818, 59004 (Nov. 21, 2018).

hospital inpatient services under the inpatient prospective payment system ("IPPS").[2] However, Medicare hospital outpatient services continued to be paid on a hospital-specific reasonable cost basis.[3]

In the Omnibus Budget Reconciliation Act of 1986 ("OBRA-86"),[4] Congress took steps to facilitate development of a prospective payment system for hospital outpatient services. In this regard, OBRA-86 § 9343(g) mandated that hospitals report claims for services using the Healthcare Common Procedure Coding System ("HCPCS") to enable the Medicare program to gather information on the specific procedures and services being furnished to Medicare beneficiaries.[5] Similarly, OBRA-86 § 9343(c) extended the prohibition against unbundling to both hospital inpatient and outpatient services[6] to ensure, in part, that all nonphysician services provided to hospital outpatients were reported on hospital bills and captured in the hospital outpatient data being used to develop the OPPS.[7]

In 1997, Congress created the statutory framework for the OPPS through § 4523 of the Balanced Budget Act of 1997 ("BBA").[8] This section established the OPPS by adding subsection (t) to 42 U.S.C § 1395l. In the CY 2019 OPPS Final Rule, the Secretary[9] gives the following color on the implementation of OPPS: "At the outset of the OPPS, there was significant concern over observed increases in the volume of outpatient services and corresponding rapidly growing beneficiary coinsurance. Accordingly, most of the focus was on finding ways to address those issues."[10]

The BBA provisions establishing OPPS also included the following statutory mandate at § 1395l(t)(2)(F): "the Secretary shall develop a method for controlling unnecessary increases in the volume of covered outpatient department (OPD) services."[11] The focus of this EJR request is on the Secretary's exercise of his authority under this statutory mandate. In the CY 2019 IPPS Final Rule, the Secretary characterized the need for this mandate as follows:

> [T]he OPPS has been the fastest growing sector of Medicare payments out of all payment systems under Medicare Parts A and B. Furthermore, we are concerned that the rate of growth suggests that payment incentives, rather than patient acuity or medical necessity, are affecting site-of-service decisionmaking. This site-of-service selection has an impact on not only the Medicare program, but also on Medicare beneficiary out-of-pocket spending.

[2] *See* 42 U.S.C. § 1395ww(d).
[3] 83 Fed. Reg. at 59004.
[4] Pub. L. 99–509, 100 Stat. 1874 (1986).
[5] *Id.* at 2041.
[6] *Id.* at 2040.
[7] *See* 83 Fed. Reg. at 59004.
[8] Pub. L. 105–33, § 4523, 111 Stat. 251 445 (1997).
[9] of the Department of Health and Human Services.
[10] 83 Fed. Reg. at 59004.
[11] BBA § 4523(a).

> Therefore, to the extent that there are lower-cost sites-of-service available, we believe that beneficiaries and the physicians treating them should have that choice and not be encouraged to receive or provide care in higher paid settings solely for financial reasons.[12]

In 2015, Congress enacted § 603 of the Bipartisan Budget Act of 2015 ("BiPBA") to, as the Secretary characterizes, "address the higher Medicare payments for services furnished in certain off-campus PBDs [*i.e*, provider-based departments] that may be associated with hospital acquisition of physicians' offices."[13] BiPBA § 603 amended 42 U.S.C. § 1395l(t) by both amending paragraph (1)(B) and adding a new paragraph (21) to which paragraph (1)(B) referred. Under these paragraphs, the Medicare program pays for "applicable items and services" furnished by certain off-campus PBDs on or after January 1, 2017 under the physician fee schedule ("PFS") rather than under the OPPS.[14,15] However, Congress created an exception in § 1395l(t)(21)(B)(ii) that grandfathers off-campus PBDs that were billing for services *prior to November 2, 2015*. Under this exception, the grandfathered off-campus PBDs (also referred to as "the excepted off-campus PBDs") continued to be paid for those services as "OPD services" under OPPS.[16] CMS implemented BiPBA § 603 as part of the CY 2017 OPPS final rule published on November 14, 2016.[17]

In the CY 2019 OPPS Final Rule, the Secretary stated that there was still concern related to the shifts in the setting of care an overutilization of the hospital outpatient setting which resulted in higher payments than if the service had been furnished in a physician office setting and that, as a result, both the Medicare program and beneficiaries continue to incur higher costs. Further, the Secretary pointed out many of the off-campus departments had converted from physicians' offices to hospital outpatient departments without a change in their location or in the acuity of patients seen. The Secretary maintained that the difference in the payment for these services has been a significant factor in the shift in services from the physician office to the hospital outpatient department.[18]

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[12] 83 Fed. Reg. at 59005.
[13] Pub. L. 114-74, § 603, 129 Stat. 584, 597 (2015).
[14] *See* 83 F. Reg. at 59007.
[15] Any off-campus department of a hospital must meet the provider-based criteria established under 42 C.F.R. § 413.65. Section 413.65(a)(2) defines "on campus" as "the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis, by the CMS regional office, to be part of the provider's campus. For an off-campus remote location to qualify for provider-based status, it must be the criteria of 42 C.F.R. § 413.65(e)(3) which requires that a provider be located within a "35-mile radius of the campus of a hospital or CAH [critical access hospital] that is the potential main provider." In the 2017 OPPS final rule published on November 14, 2016, the Secretary stated that "hospitals should use surveyor reports or other appropriate documentation to ensure that their off-campus PBDs are within 250 years (straight-line) from any point of a remote location." 81 Fed. Reg. 79562, 79703 (Nov. 14, 2016).
[16] 83 Fed. Reg. at 59008.
[17] 81 Fed. Reg. 79562, 79699-729 (Nov. 14, 2016).
[18] *Id.*

The Secretary maintains that the shift of services from the physician office to the hospital outpatient department is unnecessary if the beneficiary can safely receive the same services in a lower cost setting.[19] He maintained that the increase in the volume of outpatient clinic visits is due to the payment incentive that exists to provide the service in the higher cost setting and is unnecessary.[20] Further, the Secretary maintained that capping the OPPS at the physician fee schedule-equivalent (PFS-equivalent) rate would be an effective method to control the volume of the allegedly unnecessary services because the payment differential is driving the site of service decision and the incentive would be eliminated.[21]

Therefore, in the CY 2019 OPPS Final Rule, the Secretary used his authority at 42 U.S.C. § 1395l(t)(2)(F) to apply an amount equal to the site-specific PFS payment rate to nonexcepted items and services when provided at on off-campus PBD excepted from § 1395l(t)(21) pursuant to § 1395l(t)(21)(B)(ii) (*i.e.*, the grandfathered off-campus PBDs).[22] The Secretary is implementing this change over a 2-year phase-in period but not in a budget neutral manner.[23] The Secretary noted that, while section 1395l(t)(9)(B) requires certain changes made under the OPPS be made in a budget neutral manner, he maintains that this section does not apply to his volume control authority specified in § 1395(f)(2)(F).[24] In this regard, the Secretary claims that "this policy results in an estimated CY 2019 savings of approximately $380 million, with approximately $300 million of the savings accruing to Medicare, and approximately $80 million saved by Medicare beneficiaries in the form of reduced copayments."[25]

Providers' Position

The Providers are challenging the implementation of the "site neutral" payment cut in Medicare OPPS for the CY 2019 for "grandfathered" off-campus PBDs that were billing as provider-based prior to November 2, 2015. The Providers note that the CY 2019 OPPS Final Rule reduced the payments for clinic visit services by 30 percent in CY 2019 and 60 percent in CY 2020.

The Providers contend that the Secretary's action in the CY 2019 OPPS Final Rule is not legally permissible for two reasons: (1) the Secretary's reduction of OPPS reimbursement is an *ultra vires* action because, in so doing, he violated Congress' clear and unambiguous directive that excepted off-campus PBDs (*i.e.*, the grandfathered off-campus PBDs) be reimbursed under OPPS; and (2) the Secretary implementation of the payment cut to excepted off-campus PBDs in a nonbudget neutral manner is an *ultra vires* action because, in doing so, he violated Congress clear and unambiguous directive that all adjustments to OPPS payment rates be budget neutral.

[19] *Id.*
[20] *Id.* at 59009.
[21] *Id.*
[22] *Id.*
[23] *Id.* at 59010.
[24] *Id.*
[25] *Id.*at 59014.

With respect to the first issue, the Providers recognize that 42 U.S.C. § 1395l(t)(1)(B) clearly states that off-campus provider-based entities should be paid differently: "[f]or the purposes of this section, the term 'covered OPD services . . . does not include the applicable items and services (as defined in subparagraph (A) of paragraph (21) that are furnished on or after January 2, 2017, by an off-campus outpatient department of a provider (as defined in subparagraph (B) of such paragraph)." However, the Providers point out that Congress expressly carved out an exception from this payment change for any department billing for services *prior to November 2, 2015* (*i.e*, the grandfathered off-campus PBDs).[26] 42 U.S.C. § 1395l(t)(21)(C) is titled "Availability of payments under other payment systems" and states:

> Payments for applicable items and services furnished by an off-campus outpatient department of a provider that are described in paragraph (1)(B)(v) *shall be made* under the applicable payment system under this part (other than this subsection) if the requirements for such payment are otherwise met.[27]

Providers assert that § 1395l(t)(21)(C) clearly states that payment for non-exempted off-campus departments "shall be made" under a different payment system (*i.e*. not the OPPS) and that, therefore, Medicare payments to excepted off-campus departments (*i.e*., the grandfathered off-campus PBDs) are still to be made under OPPS.

The second issue relates to what the Providers maintain is Congress' express instruction regarding budget neutrality. The Providers explain that all payment changes to specific items or services under OPPS have to be budget neutral.[28] However, the Secretary's actions in the CY 2019 OPPS Final Rule reduced payments for clinic visits at excepted PBDs (*i.e*., the grandfathered off-campus PBDs) to align with visits at non-excepted PBS. Indeed, the Secretary notes that the change would save $380 million.

The Providers explain that an agency action is *ultra vires* when it exceeds its delegated statutory authority or when it violates a clear statutory mandate. The Providers assert that the CY 2019 OPPS Final Rule rises to an *ultra vires* action. 42 U.S.C. § 1395l(t) contains multiple provisions where Congress clearly states that excepted off-campus PBDs shall be paid differently from nonexcepted off-campus PBDs. The Providers maintain that this case clearly involves *ultra vires* action because it involves multiple statutory mandates that the agency simply did not follow.

The Providers maintain that EJR is appropriate because the Board has jurisdiction over the appeals but lacks the authority to address the legal question of whether the Secretary can promulgate a rulemaking that removes the payment exceptions established by Congress in 42 U.S.C. §§ 1395l(t)(21)(B)(ii) and 1395l(t)(21)(C). In those statutory provisions, Congress instructed the Secretary to pay new off-campus PBDs under a methodology that was not OPPS, but grandfathered locations that were clearly exempted from this requirement. Further, the

[26] 42 U.S.C. § 1395l(t)(21)(B)(ii).
[27] (Emphasis added.)
[28] 42 U.S.C. § 1395l(t)(9)(B).

Providers argue, the Secretary violated the statutory directive of 42 U.S.C. § 1395l(t)(9)(B) that requires its payment changes to specific items and services under OPPS to be budget neutral.

Decision of the Board

The participants that comprise the group appeals within this EJR request have filed appeals involving CY 2019 based on their appeal from the CY 2019 OPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants appealed from the CY 2019 OPPS Final Rule.[29] The Board has determined the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[30] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction[31] 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.

B. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's "method to control unnecessary increases in the volume of outpatient services" was made through notice and comment in the form of an uncodified regulation.[32] Specifically, in the preamble to CY 2019 OPPS Final Rule, the Secretary announced the following OPD volume control method and implementation schedule:

> After consideration of the public comments we received, we are finalizing our proposal to use our authority under [42 U.S.C. § 1395l(t)(2)(F)] to *apply* an amount equal to the site-specific PFS payment rate for nonexcepted items and services furnished by a nonexcepted off-campus PBD (*the PFS payment rate*) for the clinic visit service, as described by HCPCS code G0463, *when provided at an off-campus PBD excepted from [42 U.S.C. § 1395l(t)(21)]*

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[29] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015)

[30] *See* 42 C.F.R. § 405.1837.

[31] The Board notes that the participants in this consolidated group appeal decision have cost report periods beginning on or after January 1, 2016, which would subject their appeals to 42 C.F.R. § 405.1873 and the related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports. *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015). However, the Board notes that § 405.1873(b) has not ***yet*** been triggered because neither party has questioned whether any provider's cost report included an appropriate claim for the specific item under appeal. *See* 80 Fed. Reg. at 70556.

[32] *See* 83 Fed. Reg. 37046, 37138-37-45 (July 31, 2018) (proposed rule with section entitled "Proposal and Comment Solicitation on Method To Control for Unnecessary Increases in the Volume of Outpatient Services"); 83 Fed. Reg. at 59004-15 (final rule with section entitled "Method To Control for Unnecessary Increases in the Volume of Outpatient Services").

> (departments that bill with the modifier "PO" on claim lines[33]). In addition, we are finalizing our proposal to implement this policy in a nonbudget neutral manner. . . .
>
> In response to public comments we received, we will be phasing in the application of the reduction in payment for HCPCS code G0463 in this setting over 2 years. In CY 2019, the payment reduction will be transitioned by applying 50 percent of the total reduction in payment that would apply if these departments were paid the sitespecific PFS rate for the clinic visit service. *The final payment rates are available in Addendum B to this final rule with comment period (which is available via the internet on the CMS website).* The PFS-equivalent amount paid to nonexcepted off-campus PBDs is 40 percent of OPPS payment (that is, 60 percent less than the OPPS rate) for CY 2019. Based on a 2-year phase-in of this policy, half of the total 60-percent payment reduction, a 30-percent reduction, will apply in CY 2019. In other words, these departments will be paid approximately 70 percent of the OPPS rate (100 percent of the OPPS rate minus the 30-percent payment reduction that applies in CY 2019) for the clinic visit service in CY 2019. In CY 2020, these departments will be paid the site-specific PFS rate for the clinic visit service.[34]

The Secretary did not incorporate the above new policy setting forth an OPD volume control method into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the CY 2019 OPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

1. "After consideration of the public comments . . ., we are *finalizing our proposal* to use our authority under [§ 1395l(t)(2)(F)] *to apply* [the PFS equivalent payment rate] . . . when provided at [an excepted off-campus PBD]";

2. "[W]e are *finalizing* our proposal to implement this policy in a nonbudget neutral manner";

3. After consideration of the public comments . . ., we will be phasing in the application of the reduction on payment . . . over 2 years"; and

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[33] In the CY 2015 OPPS final rule published on November 10, 2014, the Secretary created the "PO" HCPCS modifier to be reported with every code for outpatient hospital items and services furnished in an off-campus PBD of a hospital. *See* 79 Fed. Reg. 66770, 66910-66914 (Nov. 10, 2014); CMS posting entitled "Off-Campus Provider Based Department "PO" Modifier Frequently Asked Questions" (*available at*: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Downloads/PO-Modifier-FAQ-1-19-2016.pdf).

[34] 83 Fed. Reg. at 59013-14 (emphasis added).

4. "The ***final*** *payment rates* are available at Addendum B of this final rule with comment period . . . ."[35]

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 the "Uncodified Regulation on OPD Volume Control." 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."[36]

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 to by the Uncodified Regulation on OPD Volume Control published in the CY 2019 OPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on OPD Volume Control which they allege improperly removes the payment exceptions established by Congress for outpatient services. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in these cases.

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the remaining participants' assertions regarding the CY 2019 OPPS Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Uncodified Regulation on OPD Volume Control as published in the CY 2019 OPPS Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on OPD Volume Control as published in the CY 2019 OPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the

[35] *Id.* at 59013-14 (emphasis added).
[36] 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 . . . ."

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

Board Members Participating:

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

For the Board:

7/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: John Bloom, Noridian (Electronic Mail w/Schedules of Providers)
Bruce Snyder, Novitas (Electronic Mail w/Schedules of Providers)
Byron Lamprecht, WPS (Electronic Mail w/Schedules of Providers)
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Justin Lattimore, Novitas (Electronic Mail w/Schedules of Providers)
Laurie Polson, Palmetto GBA c/o NGS (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

Exhibit P-1 – List of Cases

19-1659GC	PeaceHealth FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1667GC	Atlantic Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1668GC	Community Health Network FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1676GC	UMass Memorial Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1681GC	ProHealth Care FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1700GC	Hartford Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1701GC	Sanford Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1702GC	Rochester Regional Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1803GC	Penn State Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1856GC	Ascension Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1881G	Hall Render FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1882GC	UPMC FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1883GC	Univ of Colorado Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1900GC	Geisinger Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1905GC	Methodist Health System FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1906GC	Franciscan Alliance FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1912GC	Advocate Aurora Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1915GC	Univ of Rochester FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1916GC	Thomas Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1919GC	Samaritan Health Services FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1927GC	IU Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1940GC	Avera Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1943GC	Riverside Health FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1944GC	Regional Health, Inc. FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group
19-1945GC	NY and Presbyterian Hosp. FFY 2019 Off Campus Outpatient Site Neutral Payment CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Trinity Health
Edward Coyle
Director of Third Party Reimbursement
3805 West Chester Pike
Suite 100
Newton Square, PA 19073-2304

National Government Services, Inc.
Pam VanArsdale
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Jurisdictional Determination in Case No. 14-0343GC***
CHE 2009 Rehab LIP Medicare Advantage Dual Eligible Days Group
FYEs 12/31/2009

Dear Mr. Coyle and Ms. VanArsdale:

This case involves the Providers' appeals of Medicare reimbursement for the fiscal year ending ("FYE") on December 31, 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Rehab Low Income Patient ("LIP") Medicare Advantage Dual Eligible Days reimbursement issue and dismisses the instant appeal.

Pertinent Facts

On October 28, 2013, the group representative submitted a Request to Form Mandatory Group Appeal ("RFH") and attached the Model Form B (Group Appeal Request) in order to establish a CIRP group (Case No. 14-0343GC). The RFH included the following summarized issue:

> The common issue in this group appeal concerns the treatment in the calculation of the Medicare Low Income Patient (LIP) payment of inpatient days for patients who were enrolled in a Medicare Advantage plan under part C of the Medicare statute.[1]

[1] Model Form B- Formation of Group Appeal Request Tab 2.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Medicare Advantage Dual Eligible Days LIP Adjustment

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] 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.[4]

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[2] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[4] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek that the Board determine that the Medicare Advantage/ Dual Eligible Days be included in the numerator of the Medicaid Fraction of the Rehab LIP Calculation.[5] As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

Accordingly, the Board hereby dismisses Case No. 14-0343GC and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/31/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[5] Model Form B- Formation of Group Appeal Request Tab 2.

[6] 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).

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Novitas Solutions, Inc.
Justin Lattimore
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707 Grant St., Ste 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination for Case No. 14-1142GC***
Ardent Health 2009-2011 Dual Eligible Days LIP Adjustment CIRP Group
FYEs: 08/31/2009, 08/31/2010, 08/31/2011

Dear Ms. Erde and Mr. Lattimore:

This case involves the Providers' appeals of Medicare reimbursement for the fiscal years endings ("FYEs") on August 31, 2009, August 31, 2010, and August, 31, 2011. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Dual Eligible Days LIP Adjustment issue and dismisses the appeal.

Pertinent Facts

On November 27, 2013, the group representative submitted a Request to Form Mandatory Group Appeal ("RFH") and attached the Model Form B (Group Appeal Request) in order to establish a CIRP group (PRRB Case No. 14-1142GC). The appeal presented one issue—Dual Eligible Days LIP Adjustment—which stated that:

> The common issue relates to the treatment of patient days not covered under Medicare Part A for individuals considered as "eligible" for both Medicare Part A and Medicaid in determining the Providers' disproportionate patient percentages for purposes of the Medicare LIP adjustment.[1]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is

[1] Model Form B- Formation of Group Appeal Request at Tab 2.

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

Rehab LIP Dual Eligible Days Group

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals, District of Columbia Circuit in *Mercy Hosp., Inc. v. Azar* ("*Mercy*"), answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[3] 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.[4]

In the instant appeal, the Providers seek that the Board determine that "dual eligible" patients were incorrectly calculated in the Providers' Low Income Patient ("LIP") calculations.[5] As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this

[2] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[3] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[4] *Mercy*, 891 F.3d at 1068.
[5] Model Form B- Formation of Group Appeal Request Tab 2.

adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[6]

Accordingly, the Board hereby dismisses Case No. 14-1142GC and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/31/2019

X Clayton J. Nix

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

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

[6] 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).

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Pam VanArsdale, Appeals Lead
National Government Services, Inc.
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P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Jurisdictional Determination in Case No. 16-2383***
Mount Sinai Rehabilitation Hospital (Provider No. 07-3025)
FYE September 30, 2013

Dear Mr. Ravindran and Ms. VanArsdale:

This case involves Mount Sinai Rehabilitation Hospital's ("Mount Sinai" or "Provider") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") September 30, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Mount Sinai's documentation in response to the Medicare Contractor's May 1, 2018 Jurisdictional Challenge. Following review of the documentation, the Board finds that it does not have jurisdiction to hear Mount Sinai's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue, dismisses this issue from the instant appeal, and closes PRRB Case No. 16-2383.

Pertinent Facts

On September 8, 2016, the Board received Mount Sinai's request for a hearing ("RFH") regarding its March 8, 2016 Notice of Program Reimbursement ("NPR") for the cost reporting period ending on September 30, 2013. In its RFH, Mount Sinai lists a single issue for appeal—LIP Medicaid Eligible Days.

On May 1, 2018, the Board received the Medicare Contractor's Jurisdictional Challenge (dated April 30, 2018) in which the Medicare Contractor questions the Board's jurisdiction to consider Mount Sinai's LIP issue. Within its Jurisdictional Challenge, the Medicare Contractor argues that the language of 42 U.S.C. § 1395ww(j)(8)(B)[1] prohibits and precludes administrative and judicial review of the IRF-PPS rates established under 42 U.S.C. § 1395ww(g)(3)(A). The Medicare Contractor maintains that the payment rates for IRF's are established by the statute and are the product of (1) a rate based on historical cost and (2) adjustments to that rate based on the

[1] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 18860(7) of the Act [42 U.S.C. § l395ww(j)(7) to section 188ó(j)(8) [42 U.S.C. $ l395ww(j)(8)] and inserted a new section 1886(j)(7), which contains new requirements for the Secretary to establish a quality reporting program for IRFs.

factors set forth in the statute. Because, the statute prohibits administrative and judicial review of the LIP adjustment,[2] the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal.

Mount Sinai's response to the Medicare Contractor's Jurisdictional Challenge was received by the Board on May 30, 2018 (dated May 29, 2018). The Provider contends the regulation[3] may be challenged notwithstanding the preclusion of administrative or judicial review. Mount Sinai further asserts that the statute specifies the criteria upon which the Secretary must make adjustments to the IRF-PPS rates. Accordingly, the use of improper criteria upon which to base such adjustments would not be shielded from judicial review because such action on the part of the agency would be outside of the scope of Secretary's authority.[4]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

LIP Medicaid Eligible Rehab Days

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[5]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step

[2] 42 U.S.C. § 1395ww(j)(3)(A)(v).
[3] 42 U.S.C. § 1395ww(j).
[4] Jurisdictional Response dated May 29, 2018, at 2-3.
[5] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[6] 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.[7]

In the instant appeal, Mount Sinai seeks Board review of one of the components utilized by the Medicare Contractor to determine Mount Sinai's LIP adjustment, namely Medicaid Eligible Rehab Days. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear Mount Sinai's appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[8]

As no issues remain in the appeal, the Board hereby closes Case No. 16-2383 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/31/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[6] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[7] *Mercy*, 891 F.3d at 1068.
[8] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Noridian Healthcare Solutions
c/o Cahaba Safeguard Administrators
Lorraine Frewert
Appeals Coordinator, JE Provider Audit
P.O. Box 6782
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RE: *Jurisdictional Determination*
16-2460GC—UC 2003 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio Issued 3/16/12 CIRP Grp
16-2461GC—UC 2003 LIP Accuracy of CMS Developed SSI Ratio Issue 3/16/2012 CIRP Grp

Dear Mr. Chinea and Ms. Frewert:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") on June 30 2003. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Medicare Rehab Unit Low Income Payment ("LIP")—Dual Eligible Days or LIP Accuracy—CMS Development of the SSI Ratio issues and dismisses the instant appeals.

Pertinent Facts

On September 14, 2016, the Board received the group representative's requests for hearing ("RFH") for fiscal year end 06/30/2003. The group issue in Case No. 16-2460GC concerns the Medicare Rehab LIP—Dual Eligible Days. The group issue in Case No. 16-2461GC concerns the Medicare Rehab Unit LIP—CMS Development of the SSI Ratio.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a

specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Medicare LIP

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hosp., Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

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

In the instant appeals, the Providers seek that the Board determine that "dual eligible" patients were incorrectly calculated in the Providers' LIP calculations, and also seeks Board review of one of the components utilized by the Medicare Contractor to determine the LIP adjustments, namely the SSI percentage.[4] As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Providers' appeals of the LIP adjustment and dismisses the issues in the instant appeals that challenge this adjustment. In making this finding, the Board notes that

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[3] *Mercy*, 891 F.3d at 1068.
[4] Model Form B- Formation of Group Appeal Request Tab 2 in Case Nos. 16-2460GC and 16-2461GC.

the Court of Appeals decision in *Mercy* is controlling precedent for the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[5]

Accordingly, the Board hereby dismisses Case Nos. 16-2460GC and 16-2461GC and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

7/31/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[5] 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).

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410-786-2671

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman
500 North Meridian Street, Ste. 400
Indianapolis, IN 46204

RE: ***EJR Determination***
17-0358GC Good Shepard 2013 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 8, 2019 request for expedited judicial review ("EJR")[1](received July 10, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] This EJR request also included Case Nos. 15-2551GC and 16-2150G. The Board will issue EJR determinations for these cases under separate cover.
[2] Providers' EJR Request at 1.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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

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[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

> *part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*

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

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

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

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[17] 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.

[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[20] 69 Fed. Reg. at 49099.

> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] 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.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).

fraction had been vacated in *Allina I*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

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

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

[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.

Bowen ("*Bethesda*").[31] 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.[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 Hosp. 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 remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[36] The appeals were timely filed. The Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[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.).
[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.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

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[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/31/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Watsonville Community Hospital (Provider No. 05-0194)
FYE 12/31/2006
PRRB Case No. 17-0386

Dear Mr. Hales and Mr. Lamprecht,

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

Background

Watsonville Community Hospital is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Notice of Correction of Program Reimbursement ("Revised NPR") dated May 6, 2016 for fiscal year end ("FYE") 07/31/2006. The Provider timely filed an appeal from the revised NPR on November 2, 2016. The Model Form A-Individual Appeal Request presented one issue: DSH/SSI (Provider Specific).

On September 23, 2016, the Provider also directly added the SSI Systemic Errors issue to Case No. 16-2523GC (Quorum Health 2006 Post 1498R SSI Data Match CIRP Group).

The Medicare Contractor submitted a jurisdictional challenge over the DSH/SSI (Provider Specific) issue.

Medicare Contractor's Contentions

The Medicare Contractor contends that "[t]here was no final determination," and that "the Provider's appeal is premature as the Provider has not exhausted all available remedies."[1] The Medicare Contractor asserts that it "cannot, and did not, make a determination in terms of the Provider's SSI percentage realignment."[2] Further, the Provider is the only party who can make

[1] Medicare Contractor's Jurisdictional Challenge at 2.
[2] *Id*. at 3.

that election. However, once the election is made, the Provider is bound to it, regardless of reimbursement impact.[3]

Provider's Contentions

The Provider contends that this is an appealable issue because the Medicare Contractor specifically adjusted the Provider's SSI percentage.[4] Further, the Provider argues that the Medicare Contractor is incorrect, and that the "Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit in the 'systemic errors'."[5] Additionally, the Provider believes that it is able to identify patients who were entitled to both Medicare Part A and SSI.[6]

Board's Decision

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for this issue has two relevant components: 1) the Provider disagreed with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider reserving the right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The Provider's disagreement with the Medicare Contractor's computation of SSI percentage is duplicative of the DSH SSI Data Match issue that the Provider directly added to PRRB case number 16-2523GC (Quorum Health 2006 Post 1498R SSI Data Match CIRP Group). The Provider's SSI Provider Specific issue questions "[w]hether the Medicare Administrative Contractor ('MAC') used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ('DSH') calculation."[7] The Provider's legal basis argues that ". . . its(sic) SSI percentage published by the Centers for Medicare and Medicaid Services ('CMS') was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation," and that " . . . the SSI percentage issued by CMS is flawed."[8]

The Provider's SSI Data Match issue in the group appeal argues the Centers for Medicare and Medicaid Services and the Fiscal Intermediary failed to ". . . properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits . . . ."[9] Further, the Provider contends that "the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the numbers of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator . . . ."[10] Essentially, the Provider is arguing that its SSI percentage is inaccurate.

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[3] *Id*. at 2.
[4] Provider's Jurisdictional Response at 1.
[5] *Id*.
[6] *Id*.
[7] Provider's Individual Appeal Request Tab 3.
[8] *Id*.
[9] PRRB Case No. 16-2523GC Tab 2.
[10] *Id*.

CMS' interpretation of its regulation applies to all SSI calculations and is not specific to this provider. Because this Provider is a part of a chain, the Provider is required by CIRP regulations to pursue this issue in a CIRP group. Therefore, the Board denies jurisdiction over this issue because it is duplicative of the issue that is being pursued in the group appeal. As this Provider was directly added to a group, the Board hereby dismisses this aspect of the SSI Provider Specific Issue.

The second component of the SSI Provider Specific issue (the Provider reserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period) is also dismissed by the Board due to a lack of jurisdiction. Pursuant to 42 C.F.R. § 412.106(b)(3), when determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without the written request, the Medicare Contractor cannot issue a final determination. As there is no final determination on realignment the Board dismisses this portion of this issue statement from the appeal.

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue that was directly added to a group and because there is no final determination with respect to the realignment portion of the issue statement.

As no issues remain pending in this appeal, Case No. 17-0386 is hereby closed and removed from the Board's docket.

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

Board Members Participating:
Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

7/31/2019

X Charlotte F. Benson

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Michael G. Newell
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RE: ***EJR Determination***
18-1612GC SWC St. Elizabeth 2013 DSH Medicaid Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 9, 2019 request for expedited judicial review ("EJR")[1] (received July 12, 2019) for the appeal referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] This EJR request also included case numbers 19-2002GC, 19-2004GC and 16-2589GC. A response to the Providers' EJR request in those cases will be forthcoming under separate cover.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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

[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*

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

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

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

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[17] 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.

[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[20] 69 Fed. Reg. at 49099.

> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] 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.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).

fraction had been vacated in *Allina I*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

The two (2) participants that comprise the group appeal within this EJR request have filed appeals involving fiscal year 2013. Specifically, # 1 St. Elizabeth Medical Center (Provider No. 18-0001, FYE 12/31/2013) and # 2 St. Elizabeth Medical Center (Provider No. 18-0035, FYE 12/31/2013) appealed their revised NPRs. However, the revised NPRs from which they appealed did not adjust the Part C issue as required for Board jurisdiction, rather it was an appeal from an SSI realignment.

The regulation, 42 C.F.R. § 405.1889 (2012), provides for appeals based on revised NPRs and states:

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[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.

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

According, an appeal from a revised NPR can only be based on a matter that is "specifically revised."

42 C.F.R. § 412.106(b)(2) specifies that CMS calculates an SSI percentage on a month-by-month basis for each Federal fiscal year. The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the relevant Federal fiscal year. To do so, this regulation specifies: "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

Both St. Elizabeth Medical Centers requested that their SSI percentages be recalculated from the federal fiscal year to their respective cost reporting years. CMS does not utilize a new or different data match process[31] when it issues a realigned SSI percentage – all of the underlying data remains the same, it is simply that a different time period is used. The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated and used in the original CMS published SSI percentage) and reports it on the provider's cost reporting period instead of the September 30 FFY.

Decision of the Board

Since the revised NPRs for # 1 St. Elizabeth Medical Center (Provider No. 18-0001, FYE 12/31/2013) and # 2 St. Elizabeth Medical Center (Provider No. 18-0035, FYE 12/31/2013) did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it

[31] 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).

lacks jurisdiction over the revised NPRs and hereby dismisses the appeals for both Providers. Because these are the only providers in Case No. 18-1612GC and jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies the Providers' request for EJR and dismisses Case No. 18-1612GC.

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/31/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Judith Cummings, CGS (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway, Ste. 620
Plano, TX 75093-8724

RE: ***EJR Determination***
19-2002GC Univ. of PA Health System CY 2013 DSH Medicaid Fraction Part C Days Grp
19-2004GC Univ. of PA Health System CY 2013 DSH SSI Fraction Part C Days CIRP Grp

Dear Mr. Newell:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 9, 2019 request for expedited judicial review ("EJR")[1] (received July 12, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [W]hether Medicare Part C patients are 'entitled to benefits' under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator or vice-versa.[2]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] This EJR request also included case numbers 16-2589GC and 18-1612GC. A response to the Providers' EJR request in those cases will be forthcoming under separate cover.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[4] *Id.*

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

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

[5] *See* 42 U.S.C. § 1395ww(d)(5).
[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] (Emphasis added.)
[11] 42 C.F.R. § 412.106(b)(2)-(3).

> *part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.
[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*

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

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

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

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."[20] In response to a comment regarding this change, the Secretary explained that:

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

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[17] 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.

[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[20] 69 Fed. Reg. at 49099.

> *Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[21]

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.[22] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[25] 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.[26] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] 72 Fed. Reg. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).

fraction had been vacated in *Allina I*.[28] 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.[29] Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

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

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

Decision of the Board

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

Jurisdiction

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

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

[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] Providers' EJR Request at 1.

Bowen ("*Bethesda*").[31] 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.[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 Hosp. 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 involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. The participants' documentation shows 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.

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[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.).
[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.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

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

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

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

[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

7/31/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bruce Snyder, Novitas (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Monica Santilli
Beaumont Corporate Services
1500 Lundy Parkway
Dearborn, MI 48126

RE: ***Jurisdictional Decision in Case No. 16-1983***
Beaumont Hospital – Wayne (Provider No. 23-0142)
FYE 12/31/2013

Dear Ms. Santilli,

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

Pertinent Facts:

Beaumont Hospital – Wayne ("Provider") filed their appeal request on July 5, 2016, appealing its Notice of Program Reimbursement ("NPR") issued on January 5, 2016, for Fiscal Year Ending December 31, 2013.[1] The appeal originally contained six issues, all of which were withdrawn or transferred to group appeals at the Provider's request dated February 24, 2017. On November 1, 2017, this case was reinstated by the Board because the providers in the proposed group for the Uncompensated Care Calculation ("UCC") issue had factual differences in their arguments and thus a group was not appropriate.[2] As a result, the case was reinstated with the sole issue concerning Provider's DSH UCC payment calculation.

The Provider is arguing that there are flaws in the determination of UCC Pool payments including, but not limited to, invalid treatment of Part C days, lack of transparency in the calculations and that the best available data has not been used.[3]

The MAC filed a jurisdictional challenge on April 10, 2018, claiming this issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3), 42 C.F.R. § 412.106(g)(2).[4] They emphasize that the estimates used by the Secretary, as well as the underlying data used to generate those estimates, are both precluded from review and that the Board should dismiss this appeal as it lacks the authority over the issue. The MAC also states that there was no adjustment to the cost report made to the UCC payment, nor was it listed as an item under protest, and thus there is no determination by the

[1] Individual Appeal Request, Tab 1 (July 5, 2016).
[2] *See* Letter from the Board re: Restructure and Closure of CIRP Group (Nov. 1, 2017).
[3] Individual Appeal Request at Tab 3.
[4] *See* Medicare Administrative Contractor Jurisdictional Challenge (Apr. 10, 2018).

MAC suitable for appeal on this issue.[5] The Provider has not filed a response to the jurisdictional challenge.

Board's Decision:

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[6]
> (B) Any period selected by the Secretary for such purposes.

Further, in *Florida Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"), the D.C. Circuit Court[7] upheld a D.C. District Court decision[8] that there is no judicial or administrative review of UCC DSH payments. Specifically, in *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because, in challenging the use of the March 2013 update data, the provider was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[9] 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.[10]

The District Court 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

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[5] *Id.* at 5-6.
[6] 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.
[7] 830 F.3d 515 (D.C. Cir. 2016).
[8] 89 F. Supp. 3d 121 (D.D.C. 2015).
[9] 830 F.3d 515, 517.
[10] *Id.* at 519.

merely an attempt to undo a shielded determination.[11] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[12]

The D.C. Circuit Court addressed the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Reg'l Med. Ctr. V. Azar*, 925 F.3d 503 (D.C. Cir. 2019) ("*DCH*"). In *DCH*, 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 court 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." 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.

The Board finds that, in this case, the same findings are applicable to the Provider's challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Provider here is challenging the calculation of the amount they received for uncompensated care for FY 2014. The Board finds that, in challenging the MAC's calculation of their uncompensated care final payment amounts, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. In making this finding, the Board notes that the D.C. Circuit's decision in *Tampa General* is controlling precedent for the statutory and regulatory provisions at issue because the Provider could bring suit in the D.C. Circuit.

As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

[11] *Id.* at 521-22.
[12] *Id.* at 522.

Board Members Participating:

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

For the Board:

7/31/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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Bruce Snyder
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Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Kessler Institute for Rehab IRF LIP (Provider No. 31-3025)
FYEs 12/31/2011
Case No. 14-3680

Dear Mssrs. Snyder and Snyder:

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

Pertinent Facts

PRRB Case No. 14-3680 – Kessler Institute for Rehab (31-3025) FYE 12/31/2011

The Board received the representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to the FYE ending in 2011. In its RFH, the Provider lists one issue for appeal, relating to one subject — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] 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.[5]

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[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

Accordingly, the Board hereby closes Case No. 14-3680 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/31/2019

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

[6] 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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Baltimore, MD 21207
410-786-2671

Via Electronic Mail

Joanne Erde
Duane Morris
200 South Biscayne Blvd., Suite 600
Miami, FL 33131

Geoff Pike
First Coast Service Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Ave.
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Memorial Regional Hospital IRF LIP (Provider No. 10-0038)
FYEs: 2012, 2014
Case Nos.: 15-3052, 16-1430

Dear Ms. Erde and Mr. Pike:

These cases involve the Provider's appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2012 and 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit in *Mercy Hosp., Inc. v. Azar*, ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

PRRB Case No. 15-3052 – Memorial Regional Medical Center (10-0038) FYE 04/30/2012
PRRB Case No. 16-1430 – Memorial Regional Hospital (10-0038) FYE 04/30/2014

The Board received the representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2012 and 2014. In its RFHs, the Providers' list multiple issues for appeal, all relating to the same subject — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy*, answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] 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.[5]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or

[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

As all issues in the appeals are dismissed, the Board hereby dismisses the appeals and removes the cases from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

7/31/2019

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

[6] 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

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Via Electronic Mail

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Arcadia, CA 91006

Pam VanArsdale
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MP: INA 101-AF42
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Indianapolis, IN 46206

RE: ***Jurisdictional Determination in Case No. 17-1991***
Mount Sinai Rehabilitation Hospital IRF LIP (Provider No. 07-3025)
FYE 9/30/2014

Dear Mr. Ravindran and Ms. VanArsdale:

This case involves the Providers' appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeal.

Pertinent Facts

PRRB Case No. 17-1991 – Mount Sinai Rehabilitation Hospital (07-3025) FYE 09/30/2014

The Board received the representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to the FYE ending in 2014. In its RFH, the Providers' list multiple issues for appeal, all relating to one subject — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[2]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[3] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] 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.[5]

In the instant appeal, the Provider seeks Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the

[2] *Id*.
[3] *Id.* at 1064.
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.

instant appeals that challenge this adjustment. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for interpretation of the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[6]

Accordingly, the Board hereby closes Case No. 17-1991 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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7/31/2019

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[6] 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).