DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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RE: ***EJR Determination***
16-2225GC Community Health Network 2013 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") is in receipt of your letter dated August 9, 2019 responding to the Board's second request for additional information regarding Case No. 16-2225GC. Each of the Providers this case has a fiscal year ending on December 31, 2013, which straddles October 1, 2013, the date on which the Secretary[1] effectuated the readoption of the regulation, 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). The readoption effects discharges on or after October 31, 2013. In your response, you confirm that, notwithstanding this readoption, the Providers in the group are challenging the Medicare program's handling of their Part C days in their DSH calculations for the periods *both* prior to *and* following this readoption. Accordingly, as set forth below, the Board is denying the Provider's request for expedited judicial review ("EJR") because the Board has determined that case number 16-2225GC is not properly structured and is out of compliance with 42 C.F.R. § 405.1837(a). The Provider has ***30 days from the date this letter*** **is signed** (*i.e.*, by Monday, October 7, 2019) to request bifurcation or the Board may dismiss this case.

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 disputes the application of this policy:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment

[1] of the Department of Health and Human Services.

("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) 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 to much litigation by challenging these regulatory provisions under the Administrative Procedure Act ("APA"). In the decision for *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[5] the U.S. Circuit Court for the District of Columbia ("D.C. Circuit") vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy[6] and the subsequent regulations issued in the FFY 2008 IPPS final rule[7] codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[8] However, the Secretary has not acquiesced to that decision.

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[2] Providers' EJR request at 1.

[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] 746 F. 3d 1102 (D.C. Cir. 2014).

[6] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[7] 72 Fed. Reg. 47130, 47384, 47411 (Aug. 22, 2007) (announcing "technical corrections" to the regulatory language at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) consistent with the change adopted in the FFY 2005 IPPS final rule). 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).

[8] *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.").

Subsequently, on November 15, 2012, the D.C. Circuit issued its decision in *Allina Healthcare Services v. Sebelius* ("*Allina II*") finding in favor of the providers.[9] Following this decision, "in an abundance of caution," the Secretary published a proposed rule on May 10, 2013 to readopt the regulations codifying the FFY 2005 Part C Days Policy.[10] In the final rule published on August 19, 2013, the Secretary 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."[11] 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."[12]

All of the Providers in the current case have fiscal years that straddle October 1, 2013 and, as a result, have a portion of their fiscal year falling outside of the timeframe covered by *Allina I*. Specifically, as all of the Providers in the group have a fiscal year ending December 31, 2013, only the last quarter of 2013 (*i.e.*, October 1, 2013 through December 31, 2013) falls outside of the timeframe covered by *Allina I*. In this regard, the Board notes that, in the appeal request filed in this case, the Representative summaries the Part C issue essentially as follows:

> Providers . . . assert that any Medicare Advantage (MA or Medicare Part C) Days that are also Dual Eligible (DE) Days cannot be counted in the Medicare ratio . . . primarily because the CMS regulation requiring such inclusion in the Medicare ratio is invalid, therefore these DE-MA days must be counted in the Medicaid fraction.

As such, for the last quarter of their fiscal year, the Providers cannot obtain their requested relief (counting of any days for discharges occurring from October 1, 2013 through December 31, 2013 in the Medicaid fraction as opposed to the SSI fraction) because ***those days*** *must be counted in the SSI fraction FFY 201****4*** pursuant to the FFY 2014 Readopted Part C Days Policy.[13]

Therefore, since the there are multiple legal issues contained in Case No. 16-2225GC, the group currently is not in compliance with requirements of 42 C.F.R. § 405.1837. In particular, § 405.1837(a) specifies, in pertinent part, that there can only be one legal issue in a group appeal and that legal issue must be common to all the participants in the group:

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[9] 904 F. Supp. 2d 75 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[10] 78 Fed. Reg. 27846, 27578 (May 10, 2013).
[11] 78 Fed. Reg. 50496, 50618, 50620 (Aug. 19, 2013).
[12] *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").
[13] Similarly, the Board recognizes that each of the Providers had the SSI fraction at issue based on FFY 2013 (*i.e.*, October 1, 2012 to September 30, 2013. However, the Medicaid fraction is ***not*** based on the federal fiscal year ("FFY") but rather it is based on the hospital's fiscal year which in this case is January 1, 2013 to December 31, 2013.

> (a) Right to Board hearing as part of a group appeal: Criteria. A provider (but no other individual, entity, or party) has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . .
>
> (2) The matter at issue in the group appeal involves ***a single question*** of fact or interpretation of law, regulations, or CMS Rulings *that is* ***common to <u>each</u> provider*** *in the group*; . . . .[14]

Similarly, § 405.1837(f) specifies, in pertinent part, that the Board may not consider more than a single question of fact or law "common to each provider in the [group] appeal" and that, in those instances where the group appeal request involves more than one such question "common to each provider," there must be a bifurcation:

> The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is *common to* ***each*** *provider* in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart -
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question common to each provider; and
>
> (ii) When the appeal is found to involve more than one factual or legal question *common to* ***each*** *provider*, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.[15]

As Case No. 16-2225GC is not properly structured and is out of compliance with § 405.1837(a), the Board hereby denies the request for EJR for this case.

As Case No. 16-2225GC includes two legal issues, the Representative will need to establish another appeal and supply appropriate bifurcation and transfer requests for the providers appealing the first quarter of the FFY 2014 period ***<u>within the next 30 days</u>*** **of the date of this letter** (*i.e.*, by Monday, October 7, 2019). However, if the Representative fails to take those actions by the deadline, the Board may dismiss Case No. 16-2225GC.

[14] (Emphasis added.)
[15] (Emphasis added.)

Once the new group is established and the Schedules of Providers (with the associated jurisdictional documents) covering the first quarter of FFY 2014 (*i.e.*, October 1, 2013 to December 31, 2013) has been submitted, an EJR for the Providers who are challenging the *period **prior to** October 1, 2013* can be re-filed in this appeal.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Everts, Esq.
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FOR THE BOARD:

9/5/2019

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
17-0437G HLB Independent Hospitals 2013 DSH SSI Part C Days Group[1]

Dear Mr. Getzoff:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 17, 2019 request for expedited judicial review ("EJR") and August 9, 2019 response to the Board's request for additiona 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 the Providers' DSH payments were understated because they were calculated using a Medicare/SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[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]

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[1] This case contains ***only*** cost reporting periods *prior to October 1, 2013*. For those Providers with appeals of cost reporting periods ending December 31, 2013, the Board has bifurcated the appeal and that portion of the cost reporting period from October 1, 2013 through December 31, 2013 is now assigned to Case No. 19-2387G.
[2] Providers' EJR Request at 2.
[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 believe that by virtue of the statute, Medicare Part C days should not be included in either the numerator or denominator of the Medicare/SSI fraction. The Providers point out that in accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are "entitled to benefits under Part A" are to be included in the Medicare/SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be "eligible" for Part A, but are not "entitled" to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. As a result, the Providers assert, inpatient days associated with these patients do not belong in the Medicare/SSI fraction.

The Providers believe that EJR is appropriate because they have met the jurisdiction requirements for a group appeal because the Providers' appeal was timely filed and the $50,000 amount in controversy for a group appeal has been met. Further, the Providers assert, EJR is appropriate because the Board lacks the authority to invalidate the 2004 rule, as codified in the 2005 regulation at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year 2013 but only those periods (or portions thereof) prior to October 1, 2013 are at issue.[30]

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

[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] *See supra* note 1.

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*").[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. 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 2013 cost reporting period.[37] 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.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year[40] 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.

---

[37] *See supra* note 1.
[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] *See supra* note 1.

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

Board Members Participating:

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

FOR THE BOARD:

9/5/2019

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Lorraine Frewert, Noridian Health Care Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Eric Hogle Reimbursement Manager
University of Pittsburgh Medical
Center 600 Grant Street, 59th Floor
Pittsburgh, PA 15219

Bruce Snyder, Director
JL Provider Audit & Reimbursement
Novitas Solutions, Inc. (J-L)
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Decision in Whole***
UPMC Presbyterian Shadyside (Provider No. 39-0164)
FYE 06/30/2015
Case No. 19-2363

Dear Messrs. Hogle and Snyder:

The Provider Reimbursement Review Board (the "Board") is in receipt of the above-referenced appeal request and notes a jurisdictional impediment. The pertinent facts of the individual case and the Board's determination to dismiss this case its entirety are set forth below.

Pertinent Facts:

The Notice of Program Reimbursement ("NPR") for UPMC Presbyterian Shadyside ("Provider" or "UPMC") was issued by the Medicare Contractor on January 15, 2019. The Provider filed an individual appeal request on August 8, 2019 with a single issue under appeal—CRNA Paramedical Education Pass Through Costs. Accordingly, the Board established Case No. 19-2363 for this appeal.

Subsequently, on August 15, 2019, the Provider submitted a request to add a second issue for "Understated Standardized Amount" to the appeal and simultaneously requested to transfer this issue to Case No. 19-0171GC, the UPMC CY 2015 Understated Standardized Amount Predicate Fact CIRP Group.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to 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.

Specifically, 42 C.F.R. § 405.1835(a)(3) states that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 4.5, "[T]he date of receipt is presumed to be . . .the date of delivery as evidenced by the courier's tracking bill for documents transmitted by a nationally recognized next day courier.

In this case, the NPR was issued on January 15, 2019, and the Provider's presumed date of receipt of the final determination was January 20, 2019. Based on August 8, 2019 submission, the Board received the appeal request 200 days after the Provider's receipt of the NPR. Accordingly, the Board finds that the appeal filed by the Provider was not timely filed in accordance with the regulatory filing requirements and, hereby, ***dismisses Case No. 19-2363 in its entirety***.

Accordingly, because the Provider did not have a jurisdictionally valid appeal from the initial appeal request, the Board necessarily denies ***both*** the addition of the Understated Standardized Amount issue to the appeal ***and*** the transfer of that issue to the group appeal under Case No. 19-0171GC. As a result, UPMC Presbyterian Shadyside ***must be removed from the Schedule of Providers for Case No. 19-0171GC.*** To this end, the Board is sending a carbon copy of this dismissal to the Group Representative for Case No. 19-09171GC.

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

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

FOR THE BOARD:

9/6/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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Pam VanArsdale, Appeals Lead
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RE: Appeal of Multiple Years in a Common Issue Related Party (CIRP) Group
MaineHealth 2010-2012 Medicaid Eligible Patient Days Over Age 1 With No SSN CIRP
Case No. 19-2465GC

Dear Mr. Blumberg and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") is in receipt of a common issue related party ("CIRP") group appeal request for the MaineHealth 2010-2012 Medicaid Eligible Patient Days Over Age 1 With No SSN Issue, which Blumberg Ribner, Inc. filed on August 15, 2019. The appeal requests the transfer of the Medicaid Eligible Patient Days Over Age 1 With No SSN issue from a single provider for a span of three years (from Case Nos. 15-2744, 15-3047 and 16-0731.) In response to this request, the Board has established Case No. 19-2465GC covering fiscal years ("FYs") 2010 to 2012.

Pursuant to Board Rule 12.5:

> Providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year. However, groups may submit a written request to include more than one calendar year to meet the minimum number of providers or the $50,000 amount in controversy requirements. Failure to provide justification for an expansion of a group to cover multiple years will result in denial of the request. (Aug. 29, 2018)

The cover letter to the group appeal indicates the request for multiple years in one group is "for efficiency sake . . . as there is only two Hospitals in the MaineHealth System that has appealed this issue for a total of three Fiscal Periods." However, as the Board previously advised in a letter dated March 12, 2019 with regard to the MaineHealth Multi-Year request for 2005-2013 ***for the same issue***, the fact that there are only two providers within a chain organization is not sufficient justification to approve a multi-year group.

In the same March 12, 2019 correspondence, the Board advised that

> . . . any future requests for group appeals for this issue must be made via new, **separate group appeals *filed by year***. Future requests to form multi-year groups **must also be in compliance with Board Rule 12.5**. Specifically, your requests must **contain *a***

> ***detailed explanation*** **of why a multi-year group is needed**. Again the **fact that there are only two providers within a chain organization is *not* sufficient justification**. The Board may consider other factors, such as the **inability to form a group with at least two providers for a given year *or* the inability to meet the $50,000 threshold for that year**. In addition**, *your explanation must always address whether there are any issues of fact or changes in regulations that might result in different decisions across the years covered by the request*.** (Emphasis added.)

The Board recognizes that the first of the two providers meets the $50,000 minimum group threshold based on the initial Schedule of Providers filed with the group request. However, the Board denies the request for a multi-year group and hereby dismisses Case No. 19-2465GC because:

1) While the minimum number of providers is met, in that there are two providers in the MaineHealth chain, you have not advised whether the other Provider is pursuing the issue for any of the three years in the group request (*i.e*., FYs 2010, 2011 or 2012);

2) Separate group appeals were not filed by year as previously instructed; and

3) The explanation for your request for a multi-year group fails to address whether there are any different issues of fact or changes in the regulation across FYs 2010 to 2012.

The three requests for transfer of the Medicaid Eligible Patient Days Over Age 1 With No SSN issue are denied and the issue remains pending in the respective individual cases for Maine Medical Center, Case Nos. 15-2744, 15-3047 and 16-0731.

If you are seeking a multi-year group in the future, you must file a separate group for ***each*** year and then request that the Board consolidate the cases, provided that: (1) the minimum number of providers or the $50,000 amount in controversy requirements cannot be met; and (2) there are not any different issues of fact or changes in the regulation across the fiscal years. Note that you may also request that group appeals covering the same legal issue for various years be heard concurrently as part of a consolidated hearing in accordance with Board Rule 30.4.

Board Members:

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:

9/6/2019

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

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
St. Mary's Medical Center (Provider No. 05-0457)
FYE 6/30/08
Case No. 13-2655

Dear Ms. Bhatnagar and Mr. Lowe,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on August 7, 2013, based on a Notice of Program Reimbursement ("NPR") dated February 19, 2013. The hearing request included sixteen issues.[1] The Provider added two issues to the appeal via a request dated September 19, 2013. Six issues have been transferred to group appeals. Ten issues have been withdrawn. Two issues remain in the appeal as follows:

Issue No. 10 A – Intern and Resident (I&R) and Graduate Medical Education (GME) FTE Counts

Issue No. 14 – Nursing and Allied Health Education Payment

On July 24, 2014, the Medicare Contractor submitted a jurisdictional challenge for Issue 14.[2] On October 14, 2014, the Provider submitted a responsive brief.

Medicare Contractor's Position

The Medicare Contractor explains that the Provider is contesting the nursing and allied health managed care payment reported on Worksheet E, Part A, Line 11.01. Further, the Medicare Contractor asserts that the Provider did not claim the nursing and allied health managed care payment on its as-filed cost report. Accordingly, the Medicare Contractor maintains that it did

[1] The hearing request listed fifteen issues. Issue No. 10 was actually comprised of two issues – 10A – Intern and Resident (I&R) and Graduate Medical Education (GME) FTE Counts and 10B – Prior Year Resident to Bed Ratio.
[2] The Medicare Contractor also challenged three additional issues. The Provider subsequently withdrew them from the appeal.

not render a final determination over this additional payment. The Medicare Contractor contends that there was no adverse finding meeting the requirements of 42 C.F.R. § 405.1801(a) and that, as a result, the Provider does not have the right to an appeal for this issue.[3]

The Medicare Contractor contends that none of the adjustments related to this issue that the Provider cites in its appeal request render a determination on nursing and allied health managed care payments. The Medicare Contractor notes that the Provider filed its Medicare cost report identifying $280,000 of protested amounts. The Medicare Contractor further notes that it removed this amount via Adjustment No. 23 and that a review of the Provider's summary of protested amounts shows that the Provider did not claim a protested amount for this issue.[4]

The Medicare Contractor argues that the Provider's dissatisfaction stems from its failure to claim the nursing and allied health managed care payment on its as-filed Medicare cost report (*i.e.*, the Provider is dissatisfied with its own reporting for this additional payment). Accordingly, the Medicare Contractor maintains that the Provider failed to: (1) request from the Medicare Contractor the nursing and allied health managed care payments to which it was entitled under the applicable rules; and (2) show that, in connection with the nursing and allied health managed care payment, it faced a practical impediment to which the *Bethesda* self-disallowance rationale might attach.[5]

The Medicare Contractor explains that the nursing and allied health managed care payment is reported on Form CMS-2552-96, Worksheet E, Part A, line 11.01, of the Medicare cost report. The cost report instructions for this line state:

> Obtain the payment amounts for lines 11.01 and 11.02 from your fiscal intermediary.
>
> Line 11.01 – Enter the amount of Nursing and Allied Health Managed Care payments if applicable.

The Medicare Contractor contends that the Provider could have accurately calculated and claimed the nursing and allied health managed care payments on the as-filed cost report as an allowable amount. The Medicare Contractor points to the Provider's effort to determine the reimbursement impact for this issue and asserts that the calculation closely followed Program Memorandum A-03-043 (the "PM") that provided detailed, step-by-step instructions to follow for calculating the nursing and allied health managed care payments. Accordingly, the Medicare Contractor maintains that the Provider could have claimed the amount (*i.e.*, $78,893) on its as-filed cost report on Worksheet E, Part A, Line 11.01 and that nothing in the Medicare law, regulations, or instruction prevented the Provider from taking this approach.

[3] Medicare Contractor's jurisdictional challenge at 2.
[4] Medicare Contractor's jurisdictional challenge at 4.
[5] Medicare Contractor's jurisdictional challenge at 4-6.

The Medicare Contractor notes that it was not required by the regulations or the PM to notify the Provider of the applicable payment amount to be reported on Worksheet E, Part A, Line 11.01. Thus, the Medicare Contractor asserts that the Provider's attempt to find fault with the Medicare Contractor fails to establish that there was a practical impediment, which through no fault of its own, prevented the Provider from claiming the nursing and allied health managed care payment on its as-filed cost report.[6]

Provider's Position

In its jurisdictional response, the Provider stated that it was considering withdrawing the issue.[7]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, 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.

The Board concludes that it does not have jurisdiction over the Nursing and Allied Health Education Payment issue in this appeal because the Provider received reimbursement for the items and services as claimed on its as filed cost report and, therefore, is not dissatisfied under § 1395oo(a). Also, the Board declines to hear these matters under its discretionary powers of review pursuant to 42 U.S.C. § 1395oo(d).

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.[8] 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.[9] In addition to submitting the claims to the PS&R report, hospitals must properly report Medicare Advantage inpatient days on the Medicare cost report.[10] CMS's Cost Report Instructions for the cost reporting period under appeal state, in pertinent part:

> Obtain the payment amounts for lines 11.01 and 11.02 from your [contractor].

[6] Medicare Contractor's jurisdictional challenge at 7.
[7] The Board notes that the Provider briefed the issue in its Final Position Paper dated July 2, 2019.
[8] CMS Manual System, Pub. 100-04, Transmittal 1472 at 41, Mar. 6, 2008 *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R1472CP.pdf.
[9] *Id.*
[10] *Id.* at 42.

> Line 11.01--Enter the amount of Nursing and Allied Health Managed Care payments if applicable.[11]

The Board finds that it does not have jurisdiction over Issue No. 14 which seeks payment for Allied Nursing Health Managed Care Payments. The Provider did not include a claim for these costs on its as-filed cost report, and cost report instructions clearly dictate it was the Provider's duty to obtain and enter the relevant amount on Worksheet E, Part A, Line 11.01.

The Board has certain *discretionary powers* under 42 U.S.C. § 1395oo(d), after jurisdiction is established under 42 U.S.C. § 1395oo(a), to make a determination over all matters covered by the cost report. The Board can affirm, modify, or reverse a final determination of the Medicare contractor with respect to a cost report and make any other revisions on matters covered by the cost report even though such matters were not considered by the Medicare contractor in making its final determination.

The D.C. District Court recently upheld the Board's interpretation of the dissatisfaction requirement in § 1395oo(a) in *Saint Vincent Indianapolis Hospital v. Sebelius* 2015 WL 5728372 (D.D.C 2015) (hereinafter "*St. Vincent*"). In that case, the Board determined that the provider "failed to meet the jurisdiction prerequisite of being 'dissatisfied' with the amount of Medicare payment because the 'errors and omissions' alleged by the provider in its appeal stemmed from its own 'negligence' in understanding the Medicare regulations governing the reimbursement of such costs rather than the [Medicare Contractor's] action."[12] The Court found that the Board's ruling is "based upon a permissible construction of the statute" and, therefore, the Court affirmed the Board's dismissal.[13]

In the instant case, it is undisputed that the Provider did not include the Nursing and Allied Health Education Payment in its as-filed cost report. Only in hindsight did the Provider determine that it could have reported the payment differently, thereby increasing the amount of reimbursement. This case is precisely the situation described by the Supreme Court as being "on different ground" because the Provider "fail[ed] to request from the intermediary reimbursement for all costs to which [it was] entitled under applicable rules."[14] The Board notes that it 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 costs was not precluded by a specific law, regulation, CMS Ruling or manual instruction.[15]

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[11] Provider Reimbursement Manual Part 2, Transmittal 14 at 3630.1 (Apr. 2005) *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R14P236.pdf.
[12] *Id.* at 4 (citation omitted).
[13] *Id.*at 5.
[14] *Bethesda*, 485 U.S. at 404-405.
[15] *See, e.g.*, *Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010). This would not be a case in which the Board would deviate from this practice.

Using the rationale in the *St. Vincent* case (which addresses the *Bethesda* case), the Board finds the errors and omissions for Issue No. 14 – Nursing and Allied Health Education Payment were due solely to the Provider's negligence in understanding the Medicare regulations governing the reimbursement of such items on the Medicare cost report. The Board also finds that only when the provider has established jurisdiction under § 1395oo(a) with respect to one or more of such claims/issues can the Board then exercise discretion to hear other claims not considered by the intermediary (*e.g.*, unclaimed costs).[16] While the Provider did file a jurisdictionally valid appeal for dissatisfaction with issues other than this challenged issue that gives the Board jurisdiction under subsection (a), the Board declines to exercise discretion under 42 U.S.C. § 1395oo(d) to hear the appeal of this issue as it addresses items and services not claimed, or not properly claimed. Therefore, the Board dismisses Issue No. 14 – Nursing and Allied Health Education Payment from the appeal.[17]

As one issue remains in the appeal, the case remains open. This case is scheduled for a live hearing on October 1, 2019. Review of this decision is available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

9/6/2019

X Clayton J. Nix

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

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

[16] *See e.g.*, *Affinity Med. Ctr. v. BlueCross BlueShield Ass'n*, PRRB Dec. No. 2010-D15 (Mar. 11, 2010), *declined review*, CMS Administrator (May 3, 2010) ("*Affinity*") (analyzing a provider's right to a hearing on an issue-specific basis rather than a general basis). *See also* Board Rule 7; 73 Fed. Reg. at 30197.

[17] The Board recognizes 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Part C Days Medicaid and Medicare Proxy Groups – Board Own Motion Expedited Judicial Review Determination***

17-0524GC Capital Health 2005 DSH/Medicare Part C Days - Medicare Proxy CIRP Group
17-0523GC Capital Health 2005 DSH/Medicare Part C Days - Medicaid Proxy CIRP Group
16-1510GC Capital Health 2012 DSH Medicare Part C Days - Medicare Proxy CIRP Group
16-1511GC Capital Health 2012 DSH Medicare Part C Days - Medicaid Proxy CIRP Group

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 17, 2019, as required by 42 C.F.R. § 405.1842(c), 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. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

Issue in Dispute

The issues for which the Board is considering its own motion EJR are:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[3]

[1] The Provider's comments were received on August 12, 2019, and the Medicare contractor's comments were received on September 3, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 18, 2016), 17-0524GC.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 18, 2016), 17-0523GC.

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]

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

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

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

---

[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.

> *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 adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that 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

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.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary 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 for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later 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 regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

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

Jurisdiction for the Group Participants

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005 through 2012.

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

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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. 30,190, 30,240 (May 23, 2008).
[36] 201 F. Supp. 3d 131 (D.D.C. 2016)
[37] *Banner* at 142.

The Board has determined that the remaining participants' appeals involved with the instant EJR are governed by the decision in *Bethesda* or CMS Ruling CMS-1727-R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[38] 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 participants.

Board's Analysis Regarding the Appealed Issue

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

Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

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

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

[38] *See* 42 C.F.R. § 405.1837.
[39] *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).
[40] *See* 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

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

For the Board:

9/11/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Opelousas General Hospital (Provider No. 19-0017)
FYE 6/30/09
Case No. 14-0316

Dear Mr. Ravindran and Mr. Lattimore,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on October 18, 2013, based on a Notice of Program Reimbursement ("NPR") dated April 17, 2013. The hearing request included ten issues:

Issue 1 – Disproportionate Share Hospital Payment ("DSH")/Supplemental Security Income ("SSI") Percentage (Provider Specific)
Issue 2 - DSH/SSI (Systemic Errors)
Issue 3 – DSH Payment – Medicaid Eligible Days (*withdrawn*[1])
Issue 4 – DSH – SSI Fraction/Medicare Managed Care Part C Days
Issue 5 – DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
Issue 6 – DSH Payment – Medicaid Eligible Labor Room Days (*withdrawn*[2])
Issue 7 – DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
Issue 8 – DSHl Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
Issue 9 – Outlier Payments – Fixed Loss Threshold
Issue 10 – Rural Floor Budget Neutrality Adjustment (*withdrawn*[3])

[1] On April 23, 2014, the Medicare Contractor submitted a jurisdictional challenge on this issue. The Provider withdrew Issue 3 in a letter dated July 31, 2019 transmitting its Final Position Paper.
[2] On April 23, 2014, the Medicare Contractor submitted a jurisdictional challenge on this issue. The Provider withdrew Issue 6 in a letter dated June 17, 2014 transmitting its Preliminary Position Paper.
[3] The Provider withdrew this issue in a letter dated February 27, 2015.

Subsequently, the Provider submitted six requests dated June 17, 2014 to transfer the following issues to group appeals:

Issue 2 to Case No. 13-3931G - QRS 2009 DSH SSI Percentage Group
Issue 4 to Case No. 13-3928G - QRS 2009 DSH SSI Fraction/Medicare Managed Care Part C Days Group
Issue 5 to Case No. 13-3941G - QRS 2009 DSH Medicaid Fraction/Medicare Managed Care Part C Days Group
Issue 7 to Case No. 13-3944G - QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
Issue 8 to Case No. PRRB Case No. 13-3942G – QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
Issue 9 to Case No. 14-0728G – QRS 2009 Outlier Payments-Fixed Loss Threshold Group

The *sole* remaining issue in the appeal is Issue 1- Disproportionate Share Hospital Payment/Supplemental Security Income Percentage (Provider Specific). The Board reviewed jurisdiction over this issue on its own motion.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to 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. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction…..by…..[i]ncluding a claim for specific item(s) on its cost report…or…self-disallowing the specific item(s) by…..filing a cost report under protest…..[4]

Two of the issues that the Provider included in its hearing request were Issue 1, the DSH SSI % - Provider Specific issue, and Issue 2, DSH SSI % - Systemic Errors issue. The Provider requested that Issue 2, the DSH SSI% - Systemic Errors issue, be transferred to Case No. 13-3931G - QRS 2009 DSH SSI Percentage Group by a request dated June 17, 2014. As set forth below, the Board has determined that Issue 1, the DSH SSI % - Provider Specific issue, and Issue 2, DSH SSI% - Systemic Errors issue, to be the same issue. As such, the issue cannot be in two cases at the same time.

At the outset, the Board notes that 42 C.F.R § 405.1835(b) (2013) provides the following instructions in pertinent part regarding the content for a hearing request for each item under appeal:

4 42 C.F.R. § 405.1835(a).

> (b) *Contents of request for a Board hearing*. The provider's request for a Board hearing must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. . . .
>
> (2) **An explanation** (**for <u>each</u> specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) **Why** the provider believes **Medicare payment is incorrect** for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.[5]

Consistent with these filing requirements, the Board Rules (as published March 2013) and specifies that each issue involving DSH must be "described as narrowly as possible":

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**
>
> For each issue under appeal, give a brief summary of the determination being appealed *and the basis for dissatisfaction.* (*See Rule 8 for special instructions regarding multi-component disputes*.)
>
> **7.1 – NPR or Revised NPR Adjustments**
>
> **A. Identification of Issue**
> Give a concise issue statement describing:
> - the adjustment, including the adjustment number,
> - why the adjustment is incorrect, and
> - how the payment should be determined differently.

[5] (Bold and underline emphasis added.)

B. No Access to Data
If the Provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

7.2 – Self-Disallowed Items

A. Authority Requires Disallowance
If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:7

- a concise issue statement describing the self-disallowed item
- the reimbursement or payment sought for the item, and
- the authority that predetermined that the claim would be disallowed.

B. No Access to Data
If the Provider elects to not claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report. . . .

Rule 8 – Framing Issues for Adjustments Involving Multiple Components

8.1 – General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, *each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7*. See common examples below.

8.2 – Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, HMO days, etc.) . . . .[6]

In its appeal request, the Provider describes Issue 1 as follows:

> Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in

[6] (Italics and underline emphasis added.)

> the Disproportionate Share Hospital ("DSH") calculation. . . . The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("MCS") 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.[7]

Similarly, in the same appeal request, the Provider described Issue 2 as follows and in pertinent part:

> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage. . . .
>
> The Providers . . . contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA records, . . .
> 3. Not in agreement with provider's records . . . .

The group to which the Provider transferred Issue 2 (i.e., Case No. 13-3931G) used the same language *verbatim* to describe the group issue in the request used to form that group. Accordingly, the Board finds that both Issues 1 and 2 involve the same SSI data access and data matching process issues.

Board Rule 4.6.1 addresses "Duplicate Filings" and states: "A Provider may not appeal an issue from a single final determination in more than one appeal." As such, the Board concludes that Issue 1 – Disproportionate Share Hospital Payment/Supplemental Security Income (Provider Specific), is duplicative of Issue 2 that was transferred to Case No. 13-3931G and dismisses Issue 1 from the appeal because it is the same issue that the Provider is appealing in a separate case, Case No. 13-3931G – QRS 2009 DSH SSI Percentage Group.

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[7] (Emphasis added.)

Whereas the Provider states that SSI Ratio *Realignment* is a sub-issue of Issue 1, the Board finds that it does not have jurisdiction over the SSI Ratio Realignment issue in the appeal because there is no final determination from which the Provider is appealing, and dismisses it from the appeal. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospital's alone and the hospital must submit a written request to the Medicare Contractor in order to initiate that realignment. Without this request, it is not possible for the Medicare Contractor to have issued a final determination from which the Provider could then appeal. Furthermore, even if a Provider had made a request for realignment from the federal fiscal year to its cost reporting year, 42 C.F.R. § 405.1835(a) make clear that a Provider can only appeal from a final determination; there is no appeal right that stems from a realignment request.

As no issues remain in the appeal, the Board hereby closes the case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

9/11/2019

X Clayton J. Nix

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RE: ***Jurisdictional Decision***
Vitas Healthcare CY 2013-2015 Hospice Cap Sequestration Group
Case No. 19-2424GC
Provider – Vitas Health Corporation – Milpitas (Provider No. 05-1746, FYE 10/31/2013)

Dear Ms. Carder-Thompson and Ms. Polson,

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the documents in PRRB Case No. 19-2424GC[1] in response to the Medicare Contractor's Jurisdictional Challenge for Vitas Healthcare Corporation – Milpitas. The decision of the Board is set forth below.

Background

On May 7, 2015, the Provider, Vitas Healthcare Corporation – Milpitas, received its initial Hospice Cap Determination for fiscal year end October 31, 2013. The Provider timely filed an appeal request with the Board on October 21, 2015 from this determination for the methodology used for implementing sequestration in conjunction with its hospice payment cap overpayment.

On January 5, 2016, the Provider was issued a second revised cap determination. The Provider timely appealed this determination, which the Board incorporated into this individual appeal. On June 6, 2017, the Provider was issued a third revised cap determination. On October 11, 2017, the Board incorporated the Provider's appeal from the third revised determination into this appeal.

On May 25, 2018, the Medicare Contractor filed a jurisdictional challenge over the Provider's appeals from the revised determinations. On June 20, 2018, the Provider filed a response to the jurisdictional challenge on June 20, 2018.

[1] The jurisdictional challenge was originally filed in individual appeal under Case No. 16-0119. On August 19, 2019, the Board closed Case No. 16-0119 as the sole issue in the appeal was transferred to this newly created Common Issue Related Party (CIRP) group.

Medicare Contractor's Contentions

The Medicare Contractor argues that the Board does not have jurisdiction over the two revised determinations that the Board incorporated into this appeal. The Medicare Contractor argues that these revised cap determinations only adjusted the beneficiary count, and not the sequestration amounts that are under appeal. As such, the Medicare Contractor maintains that the Provider has not shown dissatisfaction as required by 42 U.S.C. § 1395oo(a) since no adjustment was made to the sequestration amounts, which is the issue under appeal.[2]

Provider's Contentions

The Provider counters that the Board does have jurisdiction over these revised determinations because the same flawed methodology was used to calculate the cap overpayment as was used in the original determination, which has not been challenged.[3] Since the methodology is being challenged, and that methodology is used in each determination, the Provider believes that the Board has jurisdiction over the revised determinations.[4]

Board's Decision

The Board finds that it has jurisdiction over the Provider's revised cap determinations. The Code of Federal Regulations allows MACs to reopen and revise final determinations. The principles from the regulations governing revised final determinations are applicable to revised hospice cap determinations. Specifically, 42 C.F.R. § 405.1885 (2014) provides in relevant part:

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

42 C.F.R. § 405.1889 (2014) explains the effect of a revised final determination:

> (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.

[2] Medicare Administrative Contractor's Jurisdictional Challenge at 3 (May 25, 2018).
[3] Provider's Response to the MAC's Jurisdictional Challenge at 1 (June 20, 2018).
[4] *Id.* at 3.

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

The hospice cap calculation determines the total Medicare payment for the cap year and in each determination. Congress set the amount of payment for hospice care at 42 U.S.C. § 1395f(i)(1)(A) "based on reasonable costs or other such test of reasonableness as the Secretary shall determine, subject to a[] . . . limit or cap."

Here, the Medicare Contractor issued the original hospice cap determination and three revised hospice cap determinations for the same fiscal year. In each of these determinations, the Medicare Contractor applied the ***same*** hospice cap calculation methodology in order to determine the new or revised overpayment amount due to the Medicare program. The Provider appealed the original hospice cap determination and the second and third revised hospice cap determination and it disputes the methodology used to calculate the overpayment due to the Medicare program.

Because the Provider has a valid pending appeal based on the *original* hospice cap determination challenging the methodology used to calculate the overpayment due to the Medicare program and because the second and third revised hospice cap determinations updated the overpayment due to the Medicare program using that ***same*** methodology, the Board finds that the second and third revised hospice cap determinations clearly relate to the methodology being challenged and, in particular, affect the amount in controversy at issue in this case. Accordingly, the Board finds that it has jurisdiction over the second and third revised cap determinations and that it properly incorporated the second and third revised cap determinations into this appeal.

Case No. 16-0119 remains open before the Board. 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 this appeal.

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

9/11/2019

X Clayton J. Nix

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

cc: Joe Bauers, Esq., Federal Specialized Services

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RE: **EJR Determination**
09-0667GC Ascension 2005-2006 DSH SSI Medicare Advantage Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 25, 2019 request for expedited judicial review ("EJR") (received July 26, 2019) and the response to the Board's August 21, 2019 request for information[1] that was submitted on September 5, 2019[2], 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.[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 prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

[1] The Board's August 21, 2019 Request for Information stayed the 30 day period for responding to the EJR request. 42 C.F.R. § 405.1482(e).
[2] In a submission dated September 5, 2019, the Group Representative withdrew St. Mary's Hospital (Provider No. 03-0010) for FYEs 6/30/2005 and 6/30/2006. The Group Representative submitted an updated Schedule of Providers reflecting the withdrawal.
[3] Providers' EJR Request at 1.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

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:

> 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*

[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).

> *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:

> . . . 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:

> . . . *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

[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.

> 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 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

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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).
[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.

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

The participants that comprise this group appeal within this EJR request have filed appeals involving fiscal year 2006.

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

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

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]

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.[34] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda*. 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.[35] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve 2006 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[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.

[33] *Bethesda*, 108 S. Ct. at 1258-59.
[34] See 42 C.F.R. § 405.1889(b)(1) (2008).
[35] *See* 42 C.F.R. § 405.1837.
[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'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 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) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

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Robert A. Evarts, Esq.
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FOR THE BOARD:

9/13/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Pam VanArsdale, Noridian
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RE: **EJR Determination**
16-2589GC SWC St. Elizabeth Pre 10/1//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), the Providers' August 22, 2019 response to the Board's August 7, 2019 request for additional information and the Medicare Contractor's jurisdictional review 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 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 prospective payment system ("PPS").[4] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

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[1] This EJR request also included Case Nos. 19-2002GC, 19-2004GC and 18-1612GC. A response to the Providers' EJR request in those cases has been issued.
[2] The period 10/1/2013 through 12/31/2013 has been transferred to case 19-2547GC.
[3] Providers' EJR Request at 4.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*

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:

> 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*

[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).

> *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:

> . . . 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:

> . . . *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

[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.

> 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 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

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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).
[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.

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

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal year ***prior to 10/1/2013***.

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. 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

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

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 Hosp. 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.

A. Jurisdictional Determination: Appeals of Revised NPRs and the SSI Realignment

1 St. Elizabeth Medical Center (Provider No. 18-0001, FYE 12/31/2013) and # 3 St. Elizabeth Medical Center (Provider No. 18-0035, FYE 12/31/2013) appealed their revised NPRs that did not adjust the Part C issue as required for Board jurisdiction, rather it was an appeal of an SSI realignment.

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."

[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.

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 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.[37] Rather, 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.[38]

The regulation, 42 C.F.R. § 405.1889 (2012), grants providers limited appeal rights of revised determinations:

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

Since the revised NPRs for # 1 St. Elizabeth Medical Center (Provider No. 18-0001, FYE 12/31/2013) and # 3 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,[39] the Board finds that it lacks jurisdiction over these revised NPRs and, hereby, dismisses the revised NPR appeals for both Providers. Notwithstanding, the appeal of # 2 St. Elizabeth Medical Center (Provider No. 18-0035) of its original NPR will remain pending in this case.

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[37] 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). Similarly, CMS' policy on Part C days was set in the FFY 2005 Final Rule and is incorporated into and reflected in this data matching process. *See* 75 Fed. Reg. at 50276, 50285-6.

[38] As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data on a month-by-month basis.

[39] *See supra* note 37.

B. Jurisdiction over the Remaining Provider

The Board has determined that the ***sole*** remaining participant involved with the instant EJR request (# 2 St. Elizabeth Medical Center, Provider No. 18-0035) is 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.[40][41] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the ***sole*** remaining underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involves and is limited to the ***pre-10/1/2013*** cost reporting period.[42] 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).[43] 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.[44] 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[45] and that the remaining participant in this group 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;

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[40] *See* 42 C.F.R. § 405.1837.
[41] Although this is a group appeal, only one provider remains. For administrative efficiency purposes, the Board is issuing the EJR for the sole provider remaining in the group.
[42] *See supra* note 2.
[43] *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).
[44] *See* 42 U.S.C. § 1395oo(f)(1).
[45] *See supra* note 2.

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

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

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

9/13/2019

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

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RE: ***Jurisdictional Challenge***
Newton Medical Center (Provider No. 11-0018)
FYE 12/31/2007
Case No. 13-2126

Dear Mr. Horne and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 13-2126. 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 issue within the instant appeal. There are remaining issues in the above case, and it will remain open and proceed in due course.

Background

The Provider Reimbursement Review Board (Board) received Newton Medical Center's ("Newton" or "Provider") appeal request dated May 10, 2013, related to a Notice of Program Reimbursement ("NPR") dated November 20, 2012.[1] The provider's appeal request contained the following issue statement:

> Newton Medical Center appeals whether the Medicare Administrative Contactor (MAC) was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation in accordance with 42 CFR 412.106.[2]

The Medicare administrative contractor ("MAC") filed a formal jurisdictional challenge on April 1, 2014 stating that the provider briefed a second issue, LIP Part C days in its preliminary position paper, to which the Provider has not filed a response.

The original issue statement challenged whether the Medicare Administrative Contractor was correct by including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction

[1] Providers Request for Appeal (May 10, 2013).
[2] *Id.*, at Ex. 3 (Issue Statement).

of the provider's DSH calculation. The MAC believes the Board does not have jurisdiction over the issue Medicare+Choice/Medicare Advantage Days in the LIP fraction because the Provider does not have a Rehab unit and the MAC proposed no audit adjustments to LIP calculation in its final determination on November 20, 2012, that was adverse to the Provider.[3] Also, the LIP issue was not part of the hearing request received filed with the Board, and was only addressed in the Provider's preliminary position paper.[4]

Board Determination

The Board finds that it does not have jurisdiction over the IRF-LIP issue. As promulgated at 42 C.F.R. § 405.1835, and in the Board Rules, a right to Board hearing requires that new appeals must be received by the Board no later than 180 days from the commencement of the appeal period (*i.e.*, from the date of the final determination which in this case was the Notice of Program Reimbursement ("NPR")).[5] Further, subject to the provisions of 42 C.F.R. § 405.1835(c), an issue may be added to an individual appeal if the provider timely files a request to the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request, and includes all required supporting documentation as noted in Board Rule 7.[6] As noted above, the only issue included in the initial Request for Hearing was DSH Part C days. The Provider initially raises the IRF-LIP payment issue in its Preliminary Position Paper. However, the Provider failed to file a request to properly add that issue within the requisite 240 days from the NPR.

Based on the above, the Board finds that it does not have jurisdiction over the IRF-LIP issue in the above referenced appeal because the issue was not appealed and it was improperly and untimely added. Accordingly, the Board hereby dismisses the issue.

As a result of this determination, Medicare Advantage Part C days in the DSH adjustment is the sole remaining issue in the case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/18/2019

X Clayton J. Nix

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

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

[3] MAC's Jurisdictional Challenge at 1-1 (Apr. 1, 2014).
[4] *Id*.
[5] Board Rule 4.4.1 (Aug. 29, 2018); 42 C.F.R. § 405.1835.
[6] Board Rule 6.2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Challenge***
George H. Lanier Memorial Hospital (Provider No. 01-0025)
FYE 6/30/2008
Case No. 13-2543

Dear Mr. Horne and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case No. 13-2543. 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 issue within the instant appeal. There are remaining issues in the above case, and it will remain open and proceed in due course.

Background

The Provider Reimbursement Review Board (the "Board") received the Provider's appeal request dated August 2, 2013, related to a NPR dated February 7, 2013.[1] The Provider's appeal request contained the following issue statement:

> George H. Lanier Memorial Hospital appeals whether the Medicare Administrative Contactor (MAC) was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation in accordance with 42 CFR 412.106.[2]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on June 27, 2014, stating that the provider briefed a second issue, LIP Part C days in its preliminary position paper, to which the Provider has not filed a response.

[1] Providers Request for Appeal (Aug. 2, 2013).
[2] *Id,* at Ex. 3 (Issue Statement).

Board Determination

As set for the below, the Board finds that it does not have jurisdiction over the IRF-LIP issue and dismisses the IRF-LIP issue.

As promulgated at 42 C.F.R. § 405.1835, and in the Board Rules, a right to Board hearing requires that new appeals must be received by the Board no later than 180 days from the commencement of the appeal period, i.e., the Final Determination.[3] Further, subject to the provisions of 42 C.F.R. § 405.1835(c), an issue may be added to an individual appeal if the provider timely files a request to the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 days period for filing the initial hearing request, and includes all required supporting documentation as noted in Rule 7.[4]

As noted above the only issue included in the initial Request for Hearing was ***DSH*** Part C days. While the Preliminary Position Paper seemed to have added the addition IRF-LIP payment issue, the Provider failed to timely add the issue within the requisite 240 days from the NPR pursuant to 42 C.F.R. § 405.1835(c). Accordingly, the Board finds that it does not have jurisdiction over the IRF-LIP issue in the above referenced appeal because the issue was improperly and untimely added, and the Board hereby dismisses the IRF-LIP issue.

Medicare Advantage Part C days *in the DSH adjustment* is the sole remaining issue in the case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

9/20/2019

X Clayton J. Nix

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

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

[3] Board Rule 4.4.1 (Aug. 29, 2018); 42 CFR §405.1835.
[4] Board Rule 6.2

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision***
Monterey Park Hospital (Provider No. 05-0736)
FYE 06/30/2008
Case No. 18-2236

Dear Mr. Ravindran and Ms. Frewert,

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.

Background

The Provider filed an individual appeal with the Board on May 20, 2013, which appealed a Notice of Program Reimbursement ("RNPR") dated November 26, 2012 (for the cost reporting period ending June 30, 2008). The Provider's appeal request contained five issues.

Issue 1	Medicare Part A Crossover Bad Debts
Issue 2	Disproportionate Share Hospital ("DSH") – SSI Ratio (Acute)
Issue 3	Protested Items
Issue 4	Allowable DSH Percentage
Issue 5	Medicare Part B Crossover Bad Debts

The Provider transferred multiple DSH components from protested items and the SSI ratio to multiple group appeals. On July 15, 219, the Medicare Contractor filed a jurisdictional challenge challenging the Board's jurisdiction over Issue 1 and a portion of Issues 3 and 5. On July 30, 2019, the Provider filed its jurisdictional response.

Provider summarizes its DSH/SSI – Provider Specific issue which is part of Issue 3 as follows:

> The provider is also *protesting* the exclusion of the retroactive eligibility days, … It is also protesting the fact that the SSI matching is flawed and that the SSI ratio is not based on the hospital's FYE."[1]

[1] Individual Appeal Request, Tab 3, Issue 3: Protested Items (May 15, 2013) (emphasis added).

The Provider described Issue 2, DSH/SSI – Ratio (Systemic Errors) issue, which has been transferred to a group appeal, as "the Provider believes that the adjustment understates the true SSI percentage … based on the matching of data. … the data is not based on hospital's fiscal year end, …"[2]

Medicare Contractor's Position

Challenge to SSI realignment (portion of Issue 3)

The Medicare Contractor challenges the Board's jurisdiction over the SSI realignment issue because it is a duplicate issue to Issue 2 – SSI (Systemic) ratio that was transferred to Case No. 13-2497GC.[3] The Medicare Contractor asserts that the DSH SSI Ratio - Systemic issue and DSH SSI Ratio - Provider Specific issue are considered the same by the Board and cannot be in the two cases at the same time.[4]

The Medicare Contractor also argues that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. To date, the Provider has not requested to realignment and, as such, it is not an issue that can be appealed.[5]

Challenge to Bad Debts Issues 1 and 5

The Medicare Contractor contends that the Provider failed to brief Issue 1 (Medicare Inpatient Crossover Bad Debts) and Issue 5 (Medicare Outpatient Crossover Bad Debts) in its Final Position Paper. Accordingly, the Medicare Contractor asserts that these issues have been abandoned and that the Board should dismiss these issues per Board Rule 41.2.[6]

Provider's Position

Response to SSI realignment (portion of Issue 3)

The Provider contends that each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over this case. Board Rule 8.1 states that "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…" Appeal issues #1[#3] and #2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these

[2] *Id.* Issue 2.
[3] Medicare Contractor's Jurisdictional Challenge at 2. (July 15, 2019)
[4] *Id.* at 4.
[5] *Id*. at 5-6.
[6] *Id.* at 3.

specific appeal issues represent different aspects/components of the SSI issue, the Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific issues.[7]

The Provider contends that the SSI Systemic issue is not duplicative of the SSI Provider Specific issue. The Provider is not only addressing a realignment of the SSI percentage but also addressing the various errors of omission and commission that do not fit into the "systemic errors" category.[8]

Response to Bad Debt Issues 1 and 5

The Provider requests that the Bad Debts issues (*i.e.*, Issue 1 and 5) be withdrawn from Case No. 13-2236.[9]

Board Decision:

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[10] The Board finds that the Provider timely filed its appeal and meets the amount in controversy requirement.

The Board reviewed the issue statements for Issue 2 and that portion of Issue 3 pertaining to SSI. Based upon review of these two SSI issue statements, the Board finds that the Provider is challenging the same underlying SSI data in both of its DSH/SSI issues and the two issues do not appear to be different in any significant way. Moreover, the Provider does not clarify its position in its Final Position Paper, but merely states that "CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30)."[11] The Board concludes that there is no distinction.

Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board concludes that Provider's two DSH/SSI issues are the same. Because Provider transferred Issue 2, the DSH/SSI - Systemic Errors issue, to a group appeal, the Board dismisses hereby the DSH/SSI Provider Specific issue (which was part of Issue 3) from the instant appeal.[12]

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[7] Provider's responsive brief at 1.
[8] *Id*. at 2.
[9] *Id*. at 3. Therefore, the Board need not address the Bad Debt issues.
[10] 42 U.S.C. § 1395oo(a).
[11] Provider's Final Position Paper, 8 (May 2, 2019).
[12] *See* 42 C.F.R. § 405.1837(b)(1)(i).

The Board acknowledges the Provider's withdrawal of Bad Debt Issues 1 and 5 and hereby dismisses those issues from this case.

Case No. 13-2236 remains open for the sole remaining issue, DSH Medicaid Eligible Days. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members:

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

For the Board:

9/20/2019

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 Delivery

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Cahaba Safeguard Administrators
James Lowe
Audit/Appeals Program Director
2803 Slater Road Suite 215
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RE: ***Jurisdictional Determination***
Santa Rosa Memorial Hospital (Provider No. 05-0174
FYE 6/30/09
Case No. 14-0228

Dear Ms. Giberti and Mr. Lowe,

The Provider Reimbursement Review Board (the "Board") has reviewed the jurisdictional briefs of the parties in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted a request for hearing on October 21, 2013, based on a Notice of Program Reimbursement ("NPR") dated April 26, 2013. The hearing request included fifteen issues. However, the Provider subsequently withdrew nine of those issues and transferred four issues to group appeals. As a result, there are only the following two issues remaining in this appeal:

Issue No. 5 – Medicare Disproportionate Share Hospital (DSH) Payments – Additional Medicaid Eligible Days

Issue No.15 – Medicare Rehab Low Income Patient (LIP) Payments – SSI Ratio (Protest Item)

On August 14, 2015, the Medicare Contractor submitted a jurisdictional challenge on Issue No. 15.[1] On September 10, 215, the Provider submitted a jurisdictional responsive brief.

Medicare Contractor's Position

The Medicare Contractor contends that the language of 42 U.S.C. § 1395ww(j)(8)(B)[2] unambiguously precludes administrative and judicial review of the IRF-PPS rates established

[1] The Medicare Contractor also challenged three additional LIP issues but the Provider subsequently withdrew them from the appeal.

[2] Formerly designated at paragraph (7). Section 3004(b) of the Affordable Care Act addressed the IRF PPS program and reassigned the previously-designated section 1886(j)(7) of the Act [42 U.S.C. § 1395ww(j)(7)] to section

under 42 U.S.C. § 1395ww(j)(3)(A). The Medicare Contractor maintains that, because the IRF-PPS rate is comprised of both the general federal rate based on historical costs and adjustments to that federal rate (including but not limited to the LIP adjustment at issue), the statute prohibits administrative and judicial review of the LIP adjustment.[3] Accordingly, the Medicare Contractor argues that the Board is divested of jurisdiction to hear the Provider's appeal because it must comply with all of the provisions of the Medicare Act and the regulations issued thereunder.[4]

Provider's Position

The Provider contends that the NPR issued on April 26, 2013 constitutes a final determination by the Medicare Contractor with respect to the provider's cost report. The Medicare Contractor rendered final determination and changed items of cost by implementing an audit adjustment on the appeal issue that it is being jurisdictionally challenged.[5] The Provider argues that the Medicare Contractor made an adjustment to remove the as-filed IRF protested amount totaling $50,678 in Audit Adjustment No. 34, which included a protested amounts for understated LIP payments due to an understatement of the SSI ratio as published by CMS.[6]

The Provider also contends that the Medicare Contractor did indeed post adjustments that resulted in a change to the Provider's reported IRF LIP entitlement in the Medicare cost report which thereby allows the Provider an avenue to pursue a correction to their LIP entitlement via the Board appeal process.[7]

The Provider contends that the LIP adjustment is not a component of the IRF-PPS rate described in § 1395ww(j)(3)(A) (*i.e.*, the unadjusted federal rates) because LIP is calculated as a current cost reporting period add-on payment to the IRF-PPS federal payment and it is reported on a separate line within the Medicare cost report.[8] The Provider argues that it is only disputing the accuracy of the provider-specific data elements used by the Medicare Contractor, not the establishment or methodology for development of the federal IRF prospective payments.[9] The Provider contends that § 1395ww(j)(8) does not prohibit its challenge as to whether CMS and its agents utilized the proper data elements in executing that formula. The Provider maintains that, while § 1395ww(j)(8) prohibits administrative or judicial review for certain aspects of the establishment of the IRF payments, there is no specific language within § 1395ww(j)(8) prohibiting administrative or judicial review as it pertains to the establishment of LIP.[10]

1886(j)(8) [42 U.S.C. § 1395ww(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.

[3] Medicare Contractor's jurisdictional challenge at 3-4.

[4] 42 C.F.R. § 405.1867; *Id*.

[5] Provider's jurisdictional responsive brief at 2.

[6] Provider's jurisdictional responsive brief at 4.

[7] Provider's jurisdictional responsive brief at 4.

[8] Provider's jurisdictional responsive brief at 5.

[9] Provider's jurisdictional responsive brief at 5.

[10] Provider's jurisdictional responsive brief at 5-6.

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), 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. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction…..by…..[i]ncluding a claim for specific item(s) on its cost report…or…self-disallowing the specific item(s) by…..filing a cost report under protest…..[11]

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 United States Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[12]

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.[13] 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.[14]

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 finds that it lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and should dismisses the issue in the instant appeal

[11] 42 C.F.R. § 405.1835(a).
[12] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[13] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[14] *Mercy*, 891 F.3d at 1068.

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 Provider could bring suit in the D.C. Circuit.[15]

The case remains open as there is one remaining issue, namely Issue 5 concerning DSH Medicaid eligible days. ***The Board reminds the parties that this case is scheduled for a live hearing on October 15, 2019***. Review of this decision is available under 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

9/20/2019

X Clayton J. Nix

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

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
1701 S. Racine Avenue
Chicago, IL 60608-4058

[15] 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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Cecile Huggins
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RE: Jurisdictional Determination
Provider Nos.: Various
PRRB Case Nos.:
13-2135 – Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2007
14-1219 – Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2008
14-2643 – Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2009
14-3542 – Phoebe Putney Memorial Hospital (11-0007) FYE 07/31/2010

Dear Mr. Horne and Ms. Huggins:

These cases involve the Providers' appeal of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007 to 2010. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the June 8, 2018 decision of the United States 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 related issues within the instant appeals. Each of the appeals will remain open, as each will have a sole remaining issue.

Pertinent Facts

The designated representative in each of the above cases submitted a *Request to Form Individual Appeal* ("RFH") and accordingly attached the Model Form A (Individual Appeal Request) in order to establish each case with the above assigned case number. Each appeal was based on a Notice of Program Reimbursement ("NPR") and filed timely with the Board. The RFH in the above appeals included the following summarized issues:

> The (Provider) appeals whether the MAC was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation and Low Income Patients (LIP) Rehab Payment.[2]

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *See* Provider Request for Appeal, PRRB Case Nos. *13-2135, 14-1219, 14-2643, 14-3542.*

For the LIP Rehab Payment, the Provider cites to a specific adjustment in its cost report, an update to the Low Income Patient ("LIP") SSI fraction, for Inpatient Rehab Facility ("IRF") PPS payments.

Accordingly, the LIP adjustment for IRF is the second issue in Case Nos. 13-2135, 14-1219, 14-2643, and 14-3542. The primary issues in the appeals, Part C Days in the DSH adjustment, are *not* implicated in this decision and will remain active in the above cases.

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.[3]

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."[4] 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.

[3] *Id*.
[4] *Id.* at 1064.

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.[5] 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.[6]

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 issues 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.[7]

There is one remaining issue in each of the above cases (namely the ***DSH*** Part C Days issue), and the appeals will remain open and proceed in due course.

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:

9/20/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[5] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[6] *Mercy*, 891 F.3d at 1068.
[7] 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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RE: ***Part C Days Medicaid and Medicare Proxy Groups – PRRB Own Motion Expedited Judicial Review Determination***

13-2126	Newton Medical Center (11-0018) FYE 12/31/2007
13-2135	Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2007
13-2543	George H. Lanier Memorial Hospital (01-0025) FYE 06/30/2008
14-0007	St. Joseph's Hospital (11-0043) FYE 06/30/2009
14-0009	West Georgia Medical Center (11-0016) FYE 09/30/2007
14-0010	Tanner Medical Center (11-0011) FYE 06/30/2009
14-1107	Upson Regional Medical Center (11-0002) FYE 12/31/2008
14-1207	Candler General Hospital (11-0024) FYE 06/30/2009
14-1208	George H. Lanier Memorial Hospital (01-0025) FYE 06/30/2009
14-1219	Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2008
14-2450	Upson Regional Medical Center (11-0002) FYE 12/31/2009
14-2643	Northeast Georgia Medical Center, Inc. (11-0029) FYE 09/30/2009
14-2659	Candler General Hospital (11-0024) FYE 06/30/2010
14-2662	George H. Lanier Memorial Hospital (01-0025) FYE 06/30/2010
14-2663	St. Francis Hospital (11-0129) FYE 12/31/2009
14-2665	St. Joseph's Hospital (11-0043) FYE 06/30/2010
14-2715	Colquitt Regional Medical Center (11-0105) FYE 09/30/2009
14-2830	Tanner Medical Center (11-0011) FYE 06/30/2010
14-3542	Phoebe Putney Memorial Hospital (11-0007) FYE 07/31/2010

Dear Mr. Horne:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on August 2, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced individual appeals. Although the Board has no record that the Provider submitted comments, Federal Specialized Services (FFS), on behalf of the Medicare Contractor, has submitted comments as to whether the Board is without the authority to decide the following legal question[1]:

[1] FSS's comments were received on September 3, 2019.

> Whether the MAC was correct in including Medicare + Choice/ Medicare Advantage days in the SSI/Medicare fraction of the provider's DSH Calculation in accordance with 42 CFR 412.106. Contingent upon the favorable final decision in Allina Health Services v. Sebelius. . . any Medicare Part C days removed from the Medicare faction . . . should be considered, when Medicaid eligible, as part of the Medicaid Fraction for the calculation of the DSH reimbursement.[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 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

[2] Request for Hearing, Issue Statement, at Ex. 2 (May 10, 2013), 13-2126.
[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).

> 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:

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

[10] Emphasis added.
[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] Emphasis added.
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> 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 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]

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

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[20] 69 Fed. Reg. at 49099.
[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. 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).

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.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary 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 for discharges on or after October 1, 2004.[30] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[31] The Providers point out that, because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later 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 regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to

[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *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.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.

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 addressed in this own-motion EJR determination have filed appeals involving fiscal years 2007 through 2010.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n 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 appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on

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[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, 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 own-motion EJR are governed by the decision in *Bethesda* and CMS-1727R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[37] 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 participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2007 through 2010 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[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.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the individual 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

[37] *See* 42 C.F.R. § 405.1837.
[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).

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 its Own Motion EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

For the Board:

9/24/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Joseph Glazer, Esq.
The Law Office of Joseph D. Glazer, P.C.
116 Village Blvd., Ste. 200
Princeton, NJ 08540

RE: ***Board Own Motion Expedited Judicial Review Determination***
Glazer Part C Days Medicaid and Medicare Proxy Groups
Case Nos.: *See* Appendix A for a list the 23 group appeals

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 19, 2019, as required by 42 C.F.R. § 405.1842(c), 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. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[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 Provider's comments were received on September 6, 2019, and the Medicare contractor's comments were received on September 3, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 25, 2016), 17-0582G.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Nov. 28, 2016), 17-0565G.

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

[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).

> 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

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> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[16]

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

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> . . . 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]

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

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> *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]

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[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.").

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.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary 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 for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later 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 regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdiction

The participants addressed in this own-motion EJR determination have filed appeals involving fiscal years 2005 through 2012.

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[28] 863 F.3d 937 (D.C. Cir. 2017).
[29] *Id.* at 943.
[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.

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

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda* and CMS-1727R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount

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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.

in controversy exceeds $50,000, as required for a group appeal[38] 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 participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2005 through 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).[39] 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.[40] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and

[38] *See* 42 C.F.R. § 405.1837.
[39] *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).
[40] *See* 42 U.S.C. § 1395oo(f)(1).

hereby grants its Own Motion EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

For the Board:

9/25/2019

X Clayton J. Nix

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

Enclosures: Appendix A – List of the 23 Group Appeals
Appendix B – Schedule of Providers For Each Group Appeal

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

APPENDIX A – LIST OF THE 23 GROUP APPEALS

Case Number	Case Name	FYE
17-0582G	Glazer 2005 DSH/Medicare Part C Days - Medicare Proxy Group	2005
17-0565G	Glazer 2005 DSH/Medicare Part C Days - Medicaid Proxy Group	2005
14-1326GC	Virtua 2006-2008 DSH Medicare Part C Days/Medicare Proxy CIRP Group	2006
14-1344GC	Virtua 2006-2008 DSH Medicare Part C Days/Medicaid Proxy CIRP Group	2006
14-4163GC	Cathedral 2008 DSH/Medicare Part C Days - Medicare Fraction CIRP Group	2008
14-4164GC	Cathedral 2008 DSH/Medicare Part C Days - Medicaid Fraction CIRP Group	2008
14-3823G	Glazer 2009 DSH/Medicare Part C Days - Medicare Proxy Group	2009
14-3827G	Glazer 2009 DSH/Medicare Part C Days - Medicaid Proxy Group	2009
15-0796GC	Capital Health 2009 DSH Medicare Part C Days - Medicare Proxy CIRP Group	2009
15-0797GC	Capital Health 2009 DSH Medicare Part C Days - Medicaid Proxy CIRP Group	2009
15-0895GC	Virtua 2009 DSH Medicare Part C Days-Medicaid Proxy CIRP Group	2009
15-0896GC	Virtua 2009 - 2010 DSH Medicare Part C Days-Medicare Proxy CIRP Group	2009
15-0048G	Glazer 2010 DSH Medicare Part C Days - Medicaid Proxy Group	2010
15-0049G	Glazer 2010 DSH Medicare Part C Days - Medicare Proxy Group	2010
15-0897GC	Virtua 2010 DSH Medicare Part C Days-Medicaid Proxy CIRP Group	2010
15-1971GC	Capital Health System 2010 DSH SSI Fraction Medicare Part C Days CIRP	2010
15-1972GC	Capital Health System 2010 DSH Medicaid Fraction Medicare Part C Days CIRP	2010
15-1973GC	Capital Health System 2011 DSH Medicaid Fraction Medicare Part C Days CIRP	2011
15-1974GC	Capital Health System 2011 DSH SSI Fraction Medicare Part C Days CIRP	2011
15-2993G	Glazer 2011 DSH/Medicare Part C Days - Medicare Proxy Group	2011
15-2994G	Glazer 2011 DSH/Medicare Part C Days - Medicaid Proxy Group	2011
15-2798G	Glazer 2012 DSH Medicare Part C Days - Medicaid Proxy Group	2012
15-2820G	Glazer 2012 DSH Medicare Part C Days - Medicare Proxy Group	2012

APPENDIX B
The Schedule of Providers for Each of the 23 Group Appeals

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Elizabeth A. Elias, Esq.
Hall, Render, Killian, Heath & Lyman
500 N. Meridian St., Ste. 400
Indianapolis, IN 46204-1293

RE: ***Expedited Judicial Review Determination***
72 Hall Render FFY 2019 ATRA/MACRA 0.7% D&C Groups
Case Nos.: *See attached list of 72 group appeals*

Dear Ms. Elias:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' August 28, 2019 response to the Board's August 23, 2019 notice that it was considering expedited judicial review ("EJR") on its own motion for the FY 2019 MS-DRG Documentation and Coding Adjustment issue.[1] The Board decision determining that EJR is appropriate for the issue and Federal fiscal year under appeal is set forth below.

Issue in Dispute

The Providers are challenging:

> [T]he federal standardized amount(s) ("Standardized Amount") established under the Medicare Inpatient Prospective Payment System (IPPS) for federal fiscal year ("FFY") 2019 as improper . . . . On August 17, 2018, the Secretary of the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("Secretary") published a Standardized Amount for FFY 2019 that is based in part on continuing a negative 0.7% adjustment related to the MS-DRG Documentation and Coding Adjustment in direct contravention of a statutory directive to end the negative adjustment in FFY 2017. The Secretary's error resulted in an understatement of the Standardized

[1] *See* 42 C.F.R. § 405.1842(c).

Amount, and consequently all Medicare IPPS payments to the Providers for the federal fiscal year at issue.[2]

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[7] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[8]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA

[2] Providers' Hearing Requests, Tab 2 (citation omitted).
[3] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[4] of the Department of Health and Human Services.
[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.

§ 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[9]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[10] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[11] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[12]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[13] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[14] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[15]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[16] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015,

[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.
[12] 82 Fed. Reg. at 38008.
[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.

2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[17]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[18] and the FY 2016 IPPS/LTCH PPS final rule,[19] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[23]

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[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.
[23] 82 Fed. Reg. at 38009.

The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[24]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.
[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.

The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[29] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[30]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.
[31] 78 Fed. Reg.at 50515.
[32] 83 Fed. Reg. at 41157.

Providers' Requests for Hearing

The Providers are challenging the Federal Standardized Amount for FY 2019 as improper because an alleged error reduces the Standardized Amount for this year and will reduce each subsequent fiscal year's Standardized Amount until this challenge is resolved. As part of the FY 2019 IPPS final rule published on August 17, 2018, the Secretary finalized the Standardized amount for FY 2019 that the Providers allege is based in part on continuing a negative 0.7 percent adjustment related to the MS-DRG Documentation and Coding Adjustment in direct contravention of a statutory directive to end the negative adjustment in FY 2017.[33] The Providers believe that the Secretary's error resulted in an understatement of the Standardized Amount, and, consequently, all Medicare IPPS payments to the Providers for the fiscal year at issue. The Providers believe that the decision not to eliminate the negative 0.7 percent adjustment will have an estimated $700 million impact in FY 2019.

The Providers explain that, in 2013, Congress required in ATRA § 631 that the Secretary reduce the Standardized Amount between FYs 2014 and 2017 to recoup $11 billion from hospitals subject to the MS-DRG Documentation and Coding Adjustment. The Secretary initially estimated that he could meet this obligation by implementing four consecutive, cumulative, negative 0.8 percent adjustments from FYs 2014 through 2017. As the same time this estimate was published, the Secretary announced that he planned to increase the Standardized Amount for FY 2018 by 3.2 percent to fully offset the decreases that he expected to implement between FYs 2014 and 2017. The three negative adjustments of 0.8 percent were implemented in FYs 2014, 2015 and 2016. In 2016, the Secretary asserted that, for FY 2017, a negative 1.5 percent adjustment—0.7 percent greater than originally estimated—would be necessary to fully recoup the $11 billion. The Providers note that the Secretary implemented the negative 1.5 percent adjustment, which resulted in a cumulative negative 3.9 percent adjustment from the ATRA mandate.

Further, the Providers point out that, in 2015, subsequent to the Secretary's announcement of the intention to restore 3.2 percent to the Standardized Amount in FY 2018, but prior to the Secretary's announcement of his intention to implement an additional 0.7 percent negative adjustment for FY 2017—Congress mandated that instead of a one-time positive adjustment of 3.2 percent, the Secretary was to implement six consecutive 0.5 percent adjustments from FYs 2018 to 2023. In 2016, after the Secretary announced his intention to implement an additional 0.7 percent negative adjustment to the FY 2017 Standardized Amount, Congress modified the required FY 2018 increase, reducing it from 0.5 percent to 0.4588 percent, but did not acknowledge that the estimated 3.2 percent negative adjustment had increased to 3.9 percent. [34]

The Providers assert that the Secretary has erroneously interpreted this as a mandate to retain the entire negative 0.7 percent adjustment that resulted solely from his failure to properly estimate

[33] *See id.*
[34] Providers' Hearing Requests, Tab 2.

the FY 2017 adjustment that would purportedly be necessary to complete the $11 billion recoupment. The Providers contend that the Secretary exceeded his statutory authority mandated by collecting more than $11 billion between FYs 2014 and 2019. The Providers believe that the Secretary understated the Standardized Amount for FY 2019 by failing to remove the cumulative effect of the Documentation and Coding Adjustment between FYs 2008 and 2017 before implementing adjustments applied for FY 2019.

In their response to the Board's August 23, 2019 letter requesting comments on the proposed own motion EJR, the Providers agreed with the Board's proposed EJR.

Decision of the Board

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule on August 17, 2018 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board, on its own motion, concludes that it lacks the authority to grant the relief sought by the Providers, namely to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule. Consequently, the Board hereby grants EJR on its own motion for EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, the Providers filed timely appeals of the FY 2019 IPPS Final Rule as published in the Federal Register on August 17, 2018[35] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[36] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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 the 0.7 percent reduction to the IPPS standardized amount, there are no findings of fact for resolution by the Board;

[35] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.
[36] *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 the 0.7 percent reduction to the FY 2019 IPPS standardized amount as published in the FY 2019 IPPS Final Rule, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2019 IPPS rate as published in the FY 2019 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate 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, 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 Turner, Esq.

FOR THE BOARD:

9/25/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers for 72 Group Appeals

cc: Laurie Polson, Palmetto GBA
Pam VanArsdale, NGS
Danene Hartley, NGS
Bryon Lamprecht, WPS
Justin Lattimore, Novitas Solutions
John Bloom, Noridian Healthcare Solutions
Cecile Huggins, Palmetto GBA
Bruce Snyder, Novitas Solutions
Geoff Pike, First Coast Government Services
Judith Cummings, CGS Administrators
Wilson Leong, FSS

Hall Render 2019 ATRA/MACRA Groups

Case	Group Name
19-1188GC	CarePoint Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1200GC	Baptist Health System FFY 2019 (AR) ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1206GC	Cone Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1208GC	Community Healthcare FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1209GC	Froedtert Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1210GC	Beacon Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1214GC	Beaumont Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1220GC	Univ. of PA Health System FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1225GC	Vidant Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1226GC	Aspirus Health System FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1228GC	Prisma Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1232GC	Covenant Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1248GC	Integris Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1252GC	Parkview Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1253GC	Tanner Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1255GC	Methodist Health System FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1258GC	Temple Univ Health FFY 2019 ATRA MACRA 0.7% D&C Adjustment CIRP Group
19-1261GC	Atrium Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1263GC	Univ of Rochester FFY 2019 ATRA MACRA .7% D&C Adjustment CIRP Group
19-1266GC	Spectrum Health FFY 2019 ATRA MACRA 0.7% D&C Adjustment CIRP Group
19-1273GC	Henry Ford Health FFY 2019 ATRA MACRA 0.7% D&C Adjustment CIRP Group
19-1277GC	Baptist Healthcare FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1310GC	Genesis Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1396GC	Lehigh Valley Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1398GC	ProHealth Care FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1399GC	RMC Health System FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1400GC	IU Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1401GC	Allegheny Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1403GC	Huntsville Hosp. System FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1406GC	Atlantic Health FFY 2019 ATRA MACRA 0.7% D&C Adjustment CIRP Group

19-1411GC	Inspira Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1412GC	Sinai Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1415GC	Orlando Health FFY 2019 ATRA MACRA 0.7% D&C Adjustment CIRP Group
19-1419GC	Bayhealth FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1420GC	Community Health Network FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Gr
19-1422GC	St. Elizabeth Healthcare FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1427GC	SCL Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1432GC	Rochester Regional Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1433GC	Sanford Health FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Group
19-1434GC	Premier Health Partners FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Group
19-1436GC	OSF Healthcare FFY 2019 ATRA/MACRA .7% D & C CIRP Group
19-1489GC	Roper St. Francis FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1492GC	Riverside Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1493GC	Edward-Elmhurst Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1494GC	Rush FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1495GC	Westchester Hlth Network FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Grou
19-1507GC	Infirmary Health System FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Group
19-1508GC	LCMC Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1509GC	DCH Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1512GC	Hartford Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1513GC	Kettering Health Network FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1587GC	Asante Health System FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1589GC	Mayo Clinic FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1590GC	Thomas Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1613GC	Franciscan Alliance FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1614GC	UnityPoint Health FFY 2019 ATRA MACRA 0.7% D & C Adjustment CIRP Group
19-1616GC	McLaren Health FFY 2019 ATRA MACRA 0/7% D & C Adjustment CIRP Group
19-1617GC	Ballad Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1620GC	Steward Health Care FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1646GC	Samaritan Health Services FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1655GC	Northwestern Memorial HC FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Gro
19-1656GC	WakeMed Health FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Group

19-1671GC	West TN Health FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1672GC	PeaceHealth FFY 2019 ATRA/MACRA .7% D&C Adjustment CIRP Group
19-1678GC	Avera Health FFY 2019 ATRA/MACRA .7%D&C Adjustment CIRP Group
19-1693GC	Ascension Health FFY 2019 ATRA/MACRA .7% D & C Adjustment CIRP Group
19-1706GC	Advocate Aurora Health FFY 2019 0.7% ATRA MACRA D & C Adjustment CIRP Group
19-1707GC	Northwell Health FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1710GC	UPMC FFY 2019 ATRA/MACRA 0.7% D&C Adjustment CIRP Group
19-1714G	Hall Render FFY 2019 ATRA MACRA 0.7% D & C Adjustment Group I
19-1736G	Hall Render FFY 2019 ATRA MACRA 0.7% D&C Adjustment II Group
19-1738G	Hall Render FFY 2019 ATRA MACRA 0.7% D&C Adjustment III Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Nina Adatia Marsden, Esq.
Hooper, Lundy and Bookman, P.C.
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Los Angeles, CA 90067-2517

RE: ***Board Own Motion EJR Determination***
38 Hooper, Lundy & Bookman FFY 2019 ATRA/MACRA 0.7% D&C Groups
Case Nos. *See* attached list of 32 group appeals

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the parties' responses to the Board's August 23, 2019 notice that it was considering expedited judicial review (EJR) on its own motion for the FY 2019 MS-DRG Documentation and Coding Adjustment issue.[1] The response from the Providers is dated September 23, 2019 and the response from the Medicare Administrative Contractor ("MAC") is dated September 22, 2019. The Board decision determining that EJR is appropriate for the issue and Federal fiscal year under appeal is set forth below.

Issue in Dispute

The Providers are challenging:

> . . . the authority and manner in which the Centers for Medicare & Medicaid Services ("CMS") failed to restore a 0.7% reduction to Medicare Inpatient Prospective Payment System ("IPPS") reates for inpatient discharges at all IPPS hospitals, including the Providers [in the cases on the attached list of cases], occurring on and after October 1, 2018, which affects the Providers for their fiscal years ("FYs") 2018, 2019 and 2020.[2]

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient

[1] *See* 42 C.F.R. § 405.1842(c).
[2] Providers' Hearing Requests at 1.
[3] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[4] of the Department of Health and Human Services.

classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[7] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[8]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[9]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[10] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of

[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.
[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).

the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[11] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[12]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[13] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[14] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[15]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[16] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[17]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[18] and the FY 2016 IPPS/LTCH PPS final rule,[19] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the

[11] *Id.* at 2353.
[12] 82 Fed. Reg. at 38008.
[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.
[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).

Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[23]

The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS

[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.
[23] 82 Fed. Reg. at 38009.

ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[24]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

<u>The FY 2019 Adjustment to the Standardized Amount</u>

In the Final Inpatient PPS Rule for FY 2019,[29] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ‘‘3.2 percent baseline’’ adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress’ clear instructions and intent. The commenters

[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.
[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).

requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[30]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

Providers' Requests for Hearing and Comments Regarding Own Motion EJR

The Providers contend that the Secretary improperly failed to restore the 0.7% additional ATRA reduction of the IPPS payments in violation of section 7(b)(2) of Pub. L. 110-90 [the TMA]. The Providers assert that the Secretary erroneously concluded that the additional 0.7% ATRA reduction was made permanent by MACRA and the 21st Century Cures Act, stating that "the directive regarding the applicable adjustments for FY 2018 is clear."[33] As a result, the Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FFY 2018, as required under section 15005 of Public Law 114-255"[34]

In the FFY 2019 Final Rule the Secretary reiterated his belief that "section 414 of the MACRA required that [CMS] implement a 0.5 percentage point positive adjustment for each of the FYs 2018 through 2023, and not the single adjustment [CMS] intended to make in FY 2018," and on that basis, finalized "the +0.5 percentage point adjustment to the standardized amount, as

[30] *Id.* at 41157.
[31] 78 Fed. Reg.at 50515.
[32] 83 Fed. Reg. at 41157.
[33] 82 Fed. Reg. at 38,009.
[34] *Id.*

required under section 414 of the MACRA."[35] The Providers conclude that for FFY 2019, the Secretary again, improperly maintained the 0.7% additional ATRA reduction of IPPS payments that was imposed for FY 2017.

The Providers believe that whatever Congress may have intended with the amendment section § 631(b) of ATRA by MACRA section 414 and the 21st Century Cures section 15005, it is clear that Congress did not intend to create a large, permanent, negative adjustment to the IPPS standardized amount. Despite amending 7(b) of Pub. L. 110-90 with the passage of ATRA, MACRA and the 21st Century Cures, Congress has retained the requirement that each "adjustment made under [section 7(b)(1)(B) for discharges occurring in a year . . . not be included in the determination of standardized amounts for discharges occurring in a subsequent year." The Secretary's decision to only adjust the standardized amount by +0.4588 percentage points in FFY 2018 and +0.5 percentage points in FFY 2019, and his stated plan to increase the adjustment to the standardized amount by 0.5 percentage points in FFYs 2020 through 2023, would improperly create a permanent negative reduction to payment rates in the form of a residual ATRA adjustment of negative 0.9412 percentage points in FFY 2024. The Providers assert that this is contrary to the interpretation of ATRA that the Secretary has repeatedly advanced and that was left unaltered by Congress in the MACRA and 21st Century Cures Act amendments. The Providers contend that the Secretary is obligated to fully restore the ATRA adjustment by FFY 2024 by applying the positive adjustments specified in section 414 of MACRA as amended by section 15005 of the 21st Century Cures Act, restoring the excess 0.7 percentage point negative adjustment applied in FFY 2017 and not addressed by Congress, and in FFY 2024 making a final positive adjustment to fully offset the remaining ATRA adjustments (*i.e.* 0.2412 percentage points). The Providers assert that the failure to reverse the 0.7 percentage point negative adjustment in 2018 and 2019 is contrary to the statutory mandate.
Further, the Providers argue, the Secretary improperly concluded that he lacks the discretion to apply his "exceptions and adjustments" authority under 42 U.S.C. § 1395ww(d)(5)(I) and failed to provide a rationale for declining to exercise that authority in this instance. Although commenters to the FFY 2019 proposed IPPS rule urged the Secretary to exercise his discretion under § 1395ww(d)(5)(I) to apply a positive adjustment of 0.7% in addition to the 0.5% adjustment under the 21st Century Cures Act, the Secretary did not address his discretionary adjustment authority.

In their response to the Board's August 23, 2019 letter requesting comments on the proposed own motion EJR, the Providers agreed with the Board's proposed EJR. They noted that because the Board lacks the discretion to review the questions of law presented in these appeals, EJR should be granted.

[35] *See* 82 Fed. Reg. at 41,157.

MAC's Comments Regarding Proposed Own Motion EJR

In its September 22, 2019 comments regarding the proposed own motion EJR, the MAC believes, based on the Board's previous EJR decisions, that the Board is without the authority to decide the legal question in these appeal and EJR is appropriate.

Decision of the Board

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule on August 17, 2018 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board, on its own motion, concludes that it lacks the authority to grant the relief sought by the Providers, namely to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule. Consequently, the Board hereby grants EJR on its own motion for EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, the Providers filed timely appeals of the FY 2019 IPPS Final Rule as published in the Federal Register on August 17, 2018[36] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[37] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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 the 0.7 percent reduction to the IPPS 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

[36] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.
[37] *See* 42 C.F.R. § 405.1837.

4) It is without the authority to decide the legal question of whether the 0.7 percent reduction to the FY 2019 IPPS standardized amount as published in the FY 2019 IPPS Final Rule, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2019 IPPS rate as published in the FY 2019 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate 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, 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 Turner, Esq.

FOR THE BOARD:

9/25/2019

X Clayton J. Nix

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

Enclosure: Schedules of Providers for the 38 Group Appeals

cc: Laurie Polson, Palmetto GBA
Pam VanArsdale, NGS
Danene Hartley, NGS
Bryon Lamprecht, WPS
Justin Lattimore, Novitas Solutions
John Bloom, Noridian Healthcare Solutions
Cecile Huggins, Palmetto GBA
Bruce Snyder, Novitas Solutions
Geoff Pike, First Coast Government Services
Lorraine Frewert, Noridian Healthcare Solutions
Wilson Leong, FSS

Hooper Lundy and Bookman 2019 ATRA 0.7% IPPS Payment Reduction Groups

19-1297GC	Hackensack Meridian FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1298GC	Cedars-Sinai Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1299GC	USC FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1300GC	Beth Israel Deaconness FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1301GC	Care New England FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1302GC	Baystate Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1303GC	Emory Healthcare FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1304GC	University of Chicago MC FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1305GC	UMass Memorial Health Car FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1306GC	University of California FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1309GC	UNC Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1315GC	Yale-New Haven FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1316GC	Community Med Ctrs FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1328GC	Stanford Health Care FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1329GC	Sharp Healthcare FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1332GC	SSM Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1333GC	Emanate Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1334GC	Partners FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1341GC	PIH Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1342GC	Scripps Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1343GC	Memorial Health Services FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1344GC	Lee Memorial CY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1346GC	Lahey Health System, Inc. FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1348GC	John Muir Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1349GC	Verity Health System FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1351GC	UW Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1626GC	Lifepoint Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1629GC	Ardent Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1632GC	Providence Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1641GC	Prospect Medical Holdings FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1642GC	Hospital Sisters Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1644GC	UHS FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1647GC	Dignity Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1660G	Hooper Lundy & Bookman FFY 2019 ATRA 0.7% IPPS Payment Reduction Group
19-1662GC	Tenet Healthcare FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1748G	HCA FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1757GC	CHS FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group
19-1769GC	Adventist Health FFY 2019 ATRA 0.7% IPPS Payment Reduction CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Jurisdictional Challenge***
Part C Days Issue Inclusion: No adjustment in NPR
Provider Nos.: 01-0025, 11-0002
FYE: 6/30/2009, 12/31/2009
Case Nos.: 14-1208, 14-2450

Dear Mr. Horne and Ms. Huggins:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in Case Nos. 14-1208 and 14-2450. The Board finds that it has jurisdiction to hear the Provider's Part C Days reimbursement issue. The cases will remain open and proceed in due course.

Background

A. Case No. 14-1208 – George H. Lanier Memorial Hospital (01-0025) FYE 06/30/2009

The Board received the Provider's appeal request dated December 5, 2013, related to the NPR dated June 7, 2013.[1] The Provider's appeal request contained the following issue statement:

> George H. Lanier Memorial Hospital appeals whether the Medicare Administrative Contactor (MAC) was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation in accordance with 42 CFR 412.106.[2]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on September 30, 2014 stating that the Provider contends that any Part C days removed from the SSI should be included in the Medicaid fraction, if applicable. The MAC contends that no

[1] Providers Request for Appeal (Dec. 5, 2013).
[2] *Id.*, at Ex. 3 (Issue Statement).

adjustment was made for Medicaid Eligible Days, that the Provider did not protest the issue, and that, therefore, the MAC has not made a determination with respect to the Provider for the appeal to be based on. Accordingly, the MAC requests that the Board dismiss the issue and close the case.

B. Case No. 14-2450 – Upson Regional Medical Center (11-0002) FYE 12/31/2009

The Board received the Provider's appeal request dated January 31, 2014, related to the NPR dated August 9, 2013.[3] The Provider's appeal request contained the following issue statement:

> Upson Regional Medical Center appeals whether the Medicare Administrative Contactor (MAC) was correct in including Medicare+Choice/Medicare Advantage Days in the SSI/Medicare fraction of the provider's DSH calculation in accordance with 42 CFR 412.106.[4]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on March 17, 2015, stating that the Provider contends that any part C days removed from the SSI should be included in the Medicaid fraction, if applicable. The MAC contends that no adjustment was made for Medicaid Eligible Days, that the Provider did not protest the issue, and that, therefore, the MAC has not made a determination with respect to the Provider for the appeal to be based on. Accordingly, the MAC requests that the Board dismiss the issue and close the case.

Board Determination

As set forth below, the Board finds that, for each of the Providers, it has jurisdiction over the Part C Days issue, which includes both the Medicare and Medicaid fraction.

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.[5] In both of these cases, each provider appealed from an original NPR, the amount exceeds $10,000, and each timely filed their appeal.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. 42 C.F.R. 405.1835(a)(1)(2013) 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 –

[3] Providers Request for Appeal (Jan. 31, 2014).
[4] *Id.*, at Ex. 3 (Issue Statement).
[5] Board Rule 4.4.1 (Aug. 29, 2018); 42 CFR §405.1835.

> (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 Hosp. v. Burwell* ("*Banner*")[6] 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 follows:

> …when 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].[7]

The *Banner* court looked to the Supreme Court's 1988 decision in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[8] which addressed a similar challenge to a regulation which was not first presented to the Medicare contractor. *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.[9] 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

[6] 201 F. Supp. 3d 131 (D.D.C. 2016).
[7] *Id.* at 141.
[8] 485 U.S. 399 (1988).
[9] *Id.* at 404.

> 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.[10]

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*. In this regard, 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."[11]

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 cases, the Board received the Provider's requests for hearing on December 5, 2013, and January 31, 2014. 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 fiscal year end 2009 cost reports. 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."[12]

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."[13]

In the instant appeal, the Provider questions whether the inclusion of Medicare Choice/Medicare Advantage Days in the SSI/Medicare Fraction of the Provider's DSH calculation was correct.

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[10] *Id.*
[11] Ruling 1727 at unnumbered page 2.
[12] Ruling 1727 at 6.
[13] 42 C.F.R. § 412.106(b)(4)(iii) (2010).

And that, to the extent these same days are Medicaid eligible, the days should be included in the Medicaid Fraction of the DSH calculation.[14]

As the published SSI ratios for this time period include all Part C days in the SSI fraction, and the providers were barred from also including them in their Medicaid percentage (assuming the patients were dually eligible for Medicaid and Medicare Part C). In other words, this issue meets the second requirement or step of Ruling 1727.

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.[15] 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 Dually eligible Part C/Medicaid Eligible Days sought are *not* within the payment authority or discretion of the Medicare Contractor because they are required to use the CMS issued SSI fractions per 42 C.F.R. § 412.106(b)(2) and per that regulations the SSI fraction must include Part C Days.[16]

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 dually eligible Part C/Medicaid Eligible Days are "non-allowable" costs because the Medicare Contractor was bound by 42 C.F.R. § 412.106(b)(2) and per that regulations the SSI fraction must include Part C Days.

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 dually eligible Part C/Medicaid Eligible Days issue, thus this step is not applicable to this appeal.

The Board finds that both Providers' Part C 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 the dually eligible Part C/Medicaid Eligible Days to the Medicare Contractor as they are already included in their respective SSI fraction. The Providers did not have to protest the Part C issue as the Medicare Contractor had no authority to include the days in the Medicaid fraction as CMS had already included them in their respective Medicare fraction.

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[14] Providers Request for Appeal (Dec. 5, 2013); Providers Request for Appeal (Jan. 31, 2014).
[15] 42 C.F.R. § 405.1835(a) (2010).
[16] *See* 42 C.F.R. §§ 412.106(b)(2)(i)(B), 412.106(b)(2)(iii)(B).

The Board hereby finds that it has jurisdiction over the Medicare Advantage Part C days in the DSH adjustment issue in both cases, which will proceed in due course. 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:

9/26/2019

X Clayton J. Nix

Clayton J. Nix
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 Delivery

Michael Polito
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12104 Copper Way, Suite 200
Charlotte, NC 28277

RE: ***Board Own Motion Expedited Judicial Review Determination***
New York Community Hospital Part C Days Medicaid and Medicare Proxy Appeals
13-2962 – The New York Community Hospital (33-0019) FYE 12/31/2007
14-0012 – The New York Community Hospital (33-0019) FYE 12/31/2008
14-0615 – The New York Community Hospital (33-0019) FYE 12/31/2009
15-0079 – The New York Community Hospital (33-0019) FYE 12/31/2010
15-1897 – The New York Community Hospital (33-0019) FYE 12/31/2011
16-0103 – The New York Community Hospital (33-0019) FYE 12/31/2012

Dear Mr. Polito:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced six (6) individual appeals and, on August 2, 2019, as required by 42 C.F.R. § 405.1842(c), notified the Provider that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced individual cases. Although the Board has no record that the Provider submitted comments[1], Federal Specialized Services (FFS), on behalf of the Medicare Contractor, has submitted comments as to whether the Board is without the authority to decide the following legal question[2]:

> The inclusion of the Medicare part C days in the calculation of the SSI%. . . The portion of the 2004 Final Rule that announced the Secretary's interpretation of the Medicare Disproportionate Share Fraction, as codified in 2007 and further modified in 2010 was order vacated. . . Accordingly, New York Community Hospitals of Brooklyn is appealing the DSH calculation in the revised final settlement to preserve its rights that Part C days should be excluded from the calculation of the SSI%.[3]

[1] Comments from the parties were due to the Board within 30 days of August 2, 2019, which was September 3, 2019. The Board staff emailed the representative on September 25th, 2109 to ask if comments had been previously submitted, but no response was received prior to the issuance of this letter.
[2] FSS's comments were received on September 3, 2019.
[3] Request for Hearing, at 9 (Aug. 13, 2013), PRRB Case No. 13-2962.

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]

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

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

> . . . *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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[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.

> *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 adopted in FFY 2005 IPPS rule.[27] However, the Secretary has not acquiesced to that 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

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.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary 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 for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later 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 regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

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

Jurisdiction

The participants addressed in this own-motion EJR determination have filed appeals involving fiscal years 2007 through 2012.

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

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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.

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda* and CMS-1727R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[38] 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.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2007 through 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).[39] 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.[40] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the individual 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

[38] *See* 42 C.F.R. § 405.1837.
[39] *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).
[40] *See* 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

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

For the Board:

9/27/2019

X Clayton J. Nix

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

Enclosure: List of 6 Individual Appeals

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Deborah Kantar Gardner, Esq.
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RE: ***Expedited Judicial Review Determination***
15-0015 Dana Farber Cancer Institute, Provider No. 22-0162, FYE 9/30/11
15-0251 Dana Farber Cancer Institute, Provider No. 22-0162, FYE 9/30/12

Dear Ms. Gardner:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 9, 2019 request for expedited judicial review ("EJR"), for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> Whether HHS's[1] final rule setting January 1, 2012 adjustment implementation date is invalid, and whether CMS's failure to provide for an adjustment to the Provider's payment-to-cost ratio for the calendar year 2011 violates the statutory mandate to "provide for an appropriate adjustment . . . for services furnished on or after January 1, 2011," as set forth in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 3138, 124 Stat. 119, 439 (Mar. 23, 2010) (codified at 42 U.S.C. [§] 18001 *et seq.*), and 42 U.S.C. § 1395l(t)(18)).[2]

[1] The Department of Health and Human Services.
[2] Provider's EJR request at 4.

Statutory Background

Since the inception of the hospital outpatient prospective payment system ("OPPS"), which was authorized by the Balanced Budget Act of 1997 ("BBA"),[3] the Medicare program has paid cancer hospitals identified in 42 U.S.C. § 1395ww(d)(1)(B)(v) (cancer hospitals) under the OPPS for covered outpatient hospital services. There are 11 cancer hospitals that meet the classification criteria in § 1395ww(d)(1)(B)(v). These 11 cancer hospitals are exempted from payment under the inpatient prospective payment system ("IPPS").

With the Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999,[4] Congress created 42 U.S.C. § 1395l(t)(7), ''Transitional Adjustment to Limit Decline in Payment,'' to serve as a permanent payment floor by limiting cancer hospitals' potential losses under the OPPS. Through 42 U.S.C. § 1395l(t)(7)(D)(ii), a cancer hospital receives the full amount of the difference between payments for covered outpatient services under the OPPS and a pre-BBA amount. That is, cancer hospitals are permanently held harmless to their ''pre-BBA'' amount, and they receive transitional outpatient payments ("TOPs") to ensure that they do not receive a payment that is lower under the OPPS than the payment they would have received before implementation of the OPPS, as set forth in 42 U.S.C. § 1395l(t)(7)(F). The pre-BBA payment amount is an amount equal to the product of the reasonable cost of the hospital for such services for the portions of the hospital's cost reporting period (or periods) occurring in the year and the base payment to cost ratio (base PCR) for the hospital. The pre-BBA amount, including the determination of the base PCR, are defined at 42 C.F.R. § 419.70(f). TOPs are calculated on Worksheet E Part B of the hospital cost report each year. 42 U.S.C. § 1395l(t)(7)(I) exempts TOPs from budget neutrality calculations. Almost all of the 11 cancer hospitals receive TOPs each year.[5]

In § 3138 of the Patient Protection and Affordable Care Act ("ACA"),[6] Congress instructed the Secretary to conduct a study to determine if, under the OPPS, outpatient costs incurred by cancer hospitals described in 42 U.S.C. § 1395ww(d)(1)(1)(v)(B) with respect to ambulatory classification groups exceed the costs incurred by other hospitals furnishing services under this subsection (42 U.S.C. § 1395l(t)) as determined appropriate by the Secretary. In addition, ACA § 3138 required the Secretary to take into consideration the cost of drugs and biologicals incurred by such hospitals when studying cancer hospital costliness. Further, ACA § 3138 states that if the cancer hospitals' costs are determined to be greater than the costs of other hospitals paid under the OPPS, the Secretary shall provide an appropriate adjustment to reflect these higher costs. ACA § 3138 also requires that this adjustment be budget neutral, and it would be effective for outpatient services provided at cancer hospitals on or after January 1, 2011.[7]

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[3] Pub. L. No. 105-33, § 4523, 111 Stat. 251, 445 (1997).
[4] Pub. L. No. 106-113, § 202(a)(1), 113 Stat. 1501, 1501A-342 (1999).
[5] 75 Fed. Reg. 46170, 46232-33 (Aug. 3, 2010).
[6] Pub. L. No. 111-148, § 3138, 124 Stat. 119, 439 (Mar. 23, 2010).
[7] *Id.* at 46233.

In the CY 2011 OPPS Proposed Rule,[8] the Secretary proposed an adjustment to the cancer hospital's payments to reflect those higher costs that would be effective January 1, 2011. The Secretary stated that an adjustment "would redistribute enough payments from other hospitals paid under OPPS to the cancer hospitals to give cancer hospitals a [payment to cost ratio (PCR)] that is comparable to the average PCR for other hospitals paid under the OPPS."[9] The Secretary proposed a hospital specific payment adjustment determined as the percentage of additional payment needed to raise each cancer hospital's PCR to the weighted average PCR for all other hospitals paid under OPPS in CY 2011. This would be accomplished by adjusting each cancer hospital's OPPS payment by the percentage difference between their individual PCR (without TOPs) and the weighted average PCR of other hospitals paid under OPPS.[10]

However, in the CY 2011 OPPS Final Rule,[11] the Secretary explained that commenters had identified a broad range of important issues and concerns associated with the proposed cancer hospital adjustment. After considering the comments, it had been determined that further study and deliberation related to the issues identified by the commenters was critical. This analysis would take longer than permitted in order to meet the publication date of the final rule. Consequently, the Secretary did not finalize an adjustment for certain cancer hospitals in 42 U.S.C. § 1395ww(d)(1)(B)(v).[12]

Subsequently, in the CY 2012 OPPS Final Rule,[13] the Secretary announced that, after further review and deliberation of the issues associated with cancer hospital payment adjustments in the CY 2012 OPPS Proposed Rule, she used the same approach as taken in the CY 2011 OPPS Proposed Rule.[14] Under the policy announced in the CY 2012 OPPS Final Rule, effective January 2, 2012, the payment adjustments for cancer hospitals were estimated to result in an aggregate increase of 34.5 percent and a net increase in total payment, including TOPs of 9.5 percent.[15] There was no change to the payments for CY 2011.

Provider's Position

The Provider is challenging the Secretary's failure to implement an adjustment to the Provider's PCR in calculating its CY 2011 Cancer Hospital adjustment as required by ACA § 3138 and 42 U.S.C. § 1395l(t)(18). The Provider contends that the statute plainly requires the adjustment to be effective January 1, 2011. Accordingly, the Provider asserts that the Secretary's one-year delay in the effective date to January 1, 2012 was erroneous.

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[8] 75 Fed. Reg. 46170 (Aug. 3, 2010).
[9] *Id.* at 46235.
[10] *Id.* at 46235-36.
[11] 75 Fed. Reg. 71800, 71886 (Nov. 24, 2010).
[12] *Id.*
[13] 76 Fed. Reg. 71199 (Nov. 30, 2011).
[14] *Id.*at 74202.
[15] *Id.* at 74206.

The Provider has raised a question of law regarding the validity of the CY 2011 OPPS Final Rule based on the one-year delay of the implementation date of the PCR adjustment to January 1, 2012 and the Secretary's subsequent failure to implement a required adjustment to the Provider's PCR in calculating the Provider's CY 2011 Cancer Hospital Adjustment. The Provider maintains that ACA § 3138 and 42 U.S.C. § 1395l(t)(18) required the Secretary to implement the adjustment on January 1, 2011 for CY 2011. The Provider points out that the Board lacks the authority to decide the question before it—whether the Secretary's refusal to make any adjustment to the Provider's payment-to-cost ratio for CY 2011 violates the statutory mandate to "provide for an appropriate adjustment . . . for services furnished on or after January 1, 2011."

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 Provider in each of these appeals has a fiscal year ending ("FYE") September 30th of each year. Accordingly, the Provider in this EJR request filed appeals involving those portions of its FYE 9/30/2011 and FYE 9/30/2012 that include portions of CY 2011 (*i.e.*, in Case No. 15-0015, the Provider appealed the period 1/1/2011 through 9/30/2011 and, in Case No. 15-0251, the Provider appealed the period 10/1/2011 through 12/31/2011).

For purposes of Board jurisdiction over a provider'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 issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen.*[16] 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.[17]

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[16] 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.).

[17] *Bethesda at 1258-59.*

On August 21, 2008, new regulations governing the Board were effective.[18] Among the new regulations implemented 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 before the U.S. District Court for D.C. in *Banner Heart Hosp. v. Burwell* ("*Banner*").[19] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations but did not protest the additional outlier payment it was seeking in compliance with § 405.1835(a)(1)(ii). The Board had denied the provider's request for EJR because the Board found that it lacked jurisdiction over the issue due to the provider's failure to protest that issue pursuant to § 405.1835(a)(1)(ii). 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.[20]

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*. In this regard, 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."[21]

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. The hearing requests for these appeals were filed in 2014, 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 fiscal year end 2011 and 2012 cost reports. Thus, the appealed cost reporting periods 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."[22]

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[18] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[19] 201 F. Supp. 3d 131 (D.D.C. 2016)
[20] *Banner* at 142.
[21] Ruling 1727 at unnumbered page 2.
[22] Ruling 1727 at 6.

In the instant appeals, the Provider questions whether the CY 2012 Final Rule setting January 1, 2012 adjustment implementation date is invalid, and whether CMS's failure to provide for an adjustment to the Provider's payment-to-cost ratio for CY 2011 in that final rule violates the statutory mandate to "provide for an appropriate adjustment . . . for services furnished on or after January 1, 2011." The Board finds that the Medicare Contractor and the Provider were bound by the uncodified regulations, which did not provide an adjustment to the Provider's payment-to-cost ratio for CY 2011. In other words, this issue meets the second requirement or step of Ruling 1727.

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.[23] 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. The Board finds that CMS's failure to provide for an adjustment to the Provider's payment-to-cost ratio for CY 2011 was not within the authority of the Medicare Contractor and the Medicare Contractor was unable to include any additional payments due as an allowable item.

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, the payment to cost ratio is a "non-allowable" costs because the Medicare Contractor was bound by regulations to pay in the specific manner and, thus, the Board will "not apply the self-disallowance jurisdiction regulation" in this 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 include the reimbursement impact as a protested amount on W/S E Part A, even though it was not required to do so under *Banner*. Under Step 2 above, the Board found that the item appealed was in fact non-allowable, and the Medicare Contractor was not able to provide payment and that, therefore, it was properly reported as a protested item.

Board's Analysis Regarding the Appealed Issue

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the mandate in the CY 2012 OPPS Final Rule that there be no retroactive PCR adjustment to CY 2011 for cancer hospitals

[23] 42 C.F.R. § 405.1835(a) (2010).

because CMS clearly intended to bind all cancer hospitals to this mandate and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board concludes that it lacks the authority to grant the relief sought by the Providers, namely to invalidate the CY 2012 OPPS Final Rule setting January 1, 2012 adjustment implementation date and to require CMS to provide for an adjustment to the Provider's PCR for CY 2011 as set forth in ACA § 3138 (codified at 42 U.S.C. § 1395l(t)(18)). Consequently, the Board hereby grants EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, Board finds that, consistent with Ruling 1727, it has jurisdiction over the timing of the payment to cost ratio issue in both cases because, in each case, the Provider timely filed its appeal with a proper amount in controversy and, while the Provider did not present a claim for the additional payment on the cost report, it would have been futile for the Provider to do so and it did properly include it as a protested amount. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

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 Provider in these two appeals is entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding the implementation of 42 U.S.C. § 18001 *et seq.* and 42 U.S.C. § 1395l(t)(18), 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 CY 2012 OPPS Final Rule implementing ACA § 3138 as codified at 42 U.S.C. § 1395l(t)(18) is valid.

Accordingly, the Board finds that the question of the validity of the CY 2012 OPPS Final Rule implementing ACA § 3138 as codified at 42 U.S.C. § 1395l(t)(18) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As this is the last issue in Case No. 15-0251, the appeal is now closed. As one additional issue remains in Case No 15-0015, that appeal remains open.

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:

9/27/2019

X Clayton J. Nix

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

cc: Pam VanArsdale
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Board Own Motion EJR Determination***
23 FFY 2019 ATRA/MACRA 0.7% D&C Groups
Case Nos.: *See* attached list of 23 group appeals

Dear Mr. Ravindran:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 23, 2019 response to the Board's August 28, 2019 notice that it was considering expedited judicial review (EJR) on its own motion for the FY 2019 MS-DRG Documentation and Coding Adjustment issue.[1] The Board decision determining that EJR is appropriate for the issue and Federal fiscal year under appeal is set forth below.

Issue in Dispute

The Providers are challenging the fact that:

> In both the Federal fiscal year ("FFY") 2018 and now 2019 Inpatient Prospective Payment System ("IPPS") rulemakings, CMS [the Centers for Medicare & Medicaid Services] refused to restore a 0.7 percent payment cut made in prior years under the American Taxpayer Relief Act ("ATRA"). The issue in this appeal is whether CMS acted unlawfully in refusing to restore that cut in FFY 2019.

[1] *See* 42 C.F.R. § 405.1842(c).

Statutory and Regulatory Background

In the federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[2] the Secretary[3] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believes that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[5]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[6] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[7]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[8]

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[2] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)
[3] of the Department of Health and Human Services.
[4] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[5] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[6] Pub. L. 110–90, 121 Stat. 984 (2007).
[7] *Id.* at 986.
[8] *See* 82 Fed. Reg. at 38008.

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[9] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[10] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[11]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[12] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[13] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[14]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[15] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[16]

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[9] Pub. L. 112-240, 126 Stat. 2313 (2013).
[10] *Id.* at 2353.
[11] 82 Fed. Reg. at 38008.
[12] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[13] Pub. L. 114–255, 130 Stat. 1033 (2016).
[14] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[15] 82 Fed. Reg. at 38008.
[16] *Id.*

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[17] and the FY 2016 IPPS/LTCH PPS final rule,[18] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[19] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS final rule,[20] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[21]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[22]

The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result,

[17] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[11] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[19] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[20] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[21] *Id.* at 56785.
[22] 82 Fed. Reg. at 38009.

hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[23]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[24] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[25] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[26] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[27]

<u>The FY 2019 Adjustment to the Standardized Amount</u>

In the Final Inpatient PPS Rule for FY 2019,[28] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

[23] *Id.*
[24] 81 Fed. Reg. 56783-85.
[25] *Id.* at 56784.
[26] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[27] 82 Fed. Reg. at 38009.
[28] 83 Fed. Reg. 41144 (Aug. 17, 2018).

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[29]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[30] Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[31]

Providers' Requests for Hearing and Comments Regard Own Motion EJR

The Providers explain that ATRA directed the Secretary to recoup $11 billion from hospitals by applying a reduction to the IPPS payment rates in FFYs 2014 through 2017. The Secretary initially projected that he could recoup $11 billion by applying four consecutive 0.8 percent rate cuts each year between 2014 and 2017, for a cumulative reduction of 3.2 percent by 2017. The

[29] *Id.* at 41157.
[30] 78 Fed. Reg.at 50515.
[31] 83 Fed. Reg. at 41157.

Secretary noted that the ATRA cuts were not a permanent reduction to payment rates, and that any negative adjustment would be offset by a positive adjustment once the $11 billion recoupment had been realized. Therefore, the Providers expected that the Secretary would make a one-time 3.2 percent increase in rates in FFY 2018.

However, in MACRA Congress instructed the Secretary not to make the 3.2 percent upward adjustment. Instead, MACRA instructed the Secretary to make 0.5 percent upward adjustments in each fiscal year between FFY 2018 and 2023 for a cumulative adjustment of 3.0 percent. As a result, the Providers explain, MACRA permanently cut the IPPS payment rate by 0.2 percent, thus preventing the restoration of the cumulative ATRA adjustment of 3.2 percent.

The Providers point out, in the IPPS Final Rule for 2017, the Secretary determined that it was necessary to reduce the IPPS rate by 1.5 percent in 2017 instead of 0.8 percent as originally planned. When coupled with the ATRA reductions from 2014 through 2016, this resulted in a cumulative reduction of 3.9 percent—0.7 percent higher than initially projected, and 0.9 percent higher than the 3.0 percent cumulative positive adjustment under MACRA.

Then, the Providers note, on December 13, 2016, Congress passed the 21st Century Cures Act, which replaced the 0.5 percent increase scheduled for 2018 with a 0.4588 percent increase. The remaining adjustments for years 2019 through 2023 were left at 0.5 percent.

In the IPPS Final Rule for FFY 2018, the Secretary increased the IPPS rate by 0.4588 percent. Several commenters to that rulemaking argued that the Secretary should increase the IPPS rate by an additional 0.7 percent to account for the extent to which the total ATRA reduction (3.9 percent) exceeded the initial estimate (3.2 percent). But the Secretary claimed he did not have the authority to increase the IPPS rate beyond the amounts prescribed in MACRA and the 21st Century Cures Act.

Subsequently, in the IPPS Final Rule for 2019, CMS increased the IPPS rate by only 0.5 percent. Commenters to this rulemaking again argued that the Secretary should increase the IPPS rate by and additional 0.7 percent because at the time MACRA was enacted, Congress was not aware that the Secretary would reduce rates by an additional 0.7 percent in FFY 2017. Some Commenters suggested that even if the Secretary determined that MACRA does not require a 0.7 percent adjustment, it should nonetheless exercise its statutory authority to implement the 0.7 percent adjustment to restore the standardized amount to the baseline. The Secretary again refused to make the adjustment.

The Providers contend that the Secretary acted unlawfully by failing to restore the 0.7 percent reduction through a 0.7 percent positive adjustment to the IPPS rates in 2019 and beyond. As a result, the Providers assert, the Secretary is recouping from the Providers more than the $11 billion authorized by ATRA.

The Providers believe the Secretary is statutorily required to make a curative adjustment. The TMA, provides that any downward adjustment made pursuant to ATRA must not be reflected in later years. The Secretary recognized that "the adjustment required under . . . ATRA is a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates." Nothing occurred in subsequent legislative amendments to change that fact. The Providers argue that the Secretary's failure to comply with this statutory directive to restore any reduction (absent explicit subsequent instructions) is therefore unlawful.

The Providers maintain, that a minimum, the Secretary has the discretion to restore this cut under his power to implement "exceptions and adjustments to such payment amounts . . . as [he] deems appropriate.[32] Therefore, the Secretary has created a reversible error in stating in the FFY 2019 IPPS Final Rule that he did not have the authority to make this curative adjustment. The Secretary's failure to act on its authority to restore the act is arbitrary and capricious since the Providers assert, there is no reasonable basis for maintaining this reduction after the required recoupment had been achieved.

In their response to the Board's August 28, 2019 letter requesting comments on the proposed own motion EJR, the Providers agreed with the Board's proposed EJR. They noted that, although the Board has jurisdiction over the group appeals, it does not have the authority to grant the relief sought by the Providers. Consequently, EJR should be granted.

Decision of the Board

The Board finds that, pursuant to 42 C.F.R. § 405.1867, it must comply with the 0.7 percent reduction to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule on August 17, 2018 because CMS clearly intended to bind all hospitals, which are subject to IPPS, to this payment reduction and, as such, it is an uncodified regulation adopted through the Federal Register rulemaking process. Accordingly, the Board, on its own motion, concludes that it lacks the authority to grant the relief sought by the Providers, namely to reverse or otherwise invalidate the negative adjustment of 0.7 percent to the IPPS standard amount for FY 2019 as published in the FY 2019 IPPS Final Rule. Consequently, the Board hereby grants EJR on its own motion for EJR for the issue and federal fiscal year under dispute. Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. In these cases, the Providers filed timely appeals of the FY 2019 IPPS Final Rule as published in the Federal Register on August 17, 2018[33] and the amount in

[32] 42 U.S.C. § 1395ww(d)(5)(I).

[33] In accordance with the Administrator's decision in *District of Columbia Hospital Association Wage Index Group Appeal*, (HCFA Adm. Dec. January 15, 1993) *Medicare & Medicaid Guide* (CCH) ¶ 41,025, a notice published in the Federal Register is a final determination.

controversy exceeds the $50,000 threshold for jurisdiction over each group.[34] The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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 the 0.7 percent reduction to the IPPS 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 0.7 percent reduction to the FY 2019 IPPS standardized amount as published in the FY 2019 IPPS Final Rule, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the FY 2019 IPPS rate as published in the FY 2019 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby finds that EJR is appropriate 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, 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 Turner, Esq.

FOR THE BOARD:

9/27/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers for the 23 Group Appeals

[34] *See* 42 C.F.R. § 405.1837.

cc: Laurie Polson, Palmetto GBA
Pam VanArsdale, NGS
Danene Hartley, NGS
Bryon Lamprecht, WPS
Justin Lattimore, Novitas Solutions
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QRS ATRA Cases

19-0927GC	AHMC Healthcare FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0928GC	Banner Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0929GC	Cape Fear Valley Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0930GC	Centegra Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0931GC	Skagit Regional Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0932GC	UW Medicine FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-0933G	QRS FFY 2019 ATRA IPPS Payment Reduction Group
19-0986GC	Novant Health FFY 2019 ATRA IPPS Payment Amount CIRP Group
19-0992GC	MultiCare Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1001GC	St. Luke's Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1031GC	BS&W Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1032GC	Houston Methodist FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1042GC	St. Luke's University FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1053GC	Quorum Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1057GC	Western CT Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1092GC	BayCare Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1118GC	WellStar Health FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1125GC	HonorHealth FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1139GC	BJC Healthcare FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1145GC	Health First FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1146GC	Larkin Health System FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1149GC	WVU Medicine FFY 2019 ATRA IPPS Payment Reduction CIRP Group
19-1233G	QRS FFY 2019 ATRA IPPS Payment Reduction (2) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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RE: ***Board Own Motion Expedited Judicial Review Determination***
Part C Days Medicaid and Medicare Proxy Groups
16-0073GC – Virtua Health 2012 DSH Medicare Part C Days - Medicare Proxy CIRP Group
16-0074GC – Virtua Health 2012 DSH Medicare Part C Days - Medicaid Proxy CIRP Group

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced group appeals and, on July 17, 2019, as required by 42 C.F.R. § 405.1842(c), 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. The Providers and the Medicare Contractor have also submitted comments as to whether the Board is without the authority to decide the following legal questions[1]:

> Whether the Intermediary wrongfully include the Provider's Medicare part C days in the Medicare Proxy used to calculate the Provider's allowable Medicare disproportionate share payment.[2]
>
> And,
> Whether the Intermediary failed to include all of the Provider's Medicare part C days in the numerator of the Medicaid Proxy used to calculate the Provider's allowable Medicare disproportionate Share hospital (DSH) payment.[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 Provider's comments were received on August 12, 2019, and the Medicare contractor's comments were received on September 3, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 2 (Oct. 15, 2015), 16-0073GC.
[3] Request for Hearing, Issue Statement, at Ex. 2 (Oct. 15, 2015), 16-0074GC.

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).
[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).

> 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:

> . . . 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:

> *. . . 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*

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[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.

> *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 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

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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.

Medicare fractions published for FY 2012.[30] Once again, the Secretary has not acquiesced to this decision.

Board's Consideration for Own Motion EJR

In the FFY 2005 Final Rule, the Secretary 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 for discharges on or after October 1, 2004.[31] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[32] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later 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 regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdiction

The participants addressed in this own-motion EJR determination have filed appeals involving fiscal year 2012.

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*

[30] *Id.* at 943-945.
[31] 69 Fed. Reg. at 49,099.
[32] *Allina* at 1109.
[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*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' appeals involved with the instant own-motion EJR are governed by the decision in *Banner* and CMS-1727R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[36] 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 participants.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal year 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

[34] 201 F. Supp. 3d 131 (D.D.C. 2016)
[35] *Id.* at 142.
[36] *See* 42 C.F.R. § 405.1837.
[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).

above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

For the Board:

9/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

The Mosaic of Lake Shore
Nesanel Davis
4600 W Touhy Suite 200
Lincolnwood, IL 60712

CGS Administrators
Judith Cummings
Accounting Manager
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: ***Case Dismissal***
The Mosaic of Lake Shore (14-5244)
Federal Fiscal Year 2019
Case No. 19-0531

Dear Mr. Davis and Ms. Cummings,

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned appeal. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

The Provider filed an appeal on December 19, 2018. The Board sent an acknowledgement and critical due dates notice on January 10, 2019 ("Acknowledgement and Critical Due Dates Notice") with a Provider preliminary position paper due date of August 16, 2019. This notice also included the warning to the Provider that "The parties must meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests. If the Provider misses any of its due dates, the Board ***will dismiss*** the appeal."[1]

The Provider submitted its preliminary position paper on August 28, 2019. The Board notes that the Provider uploaded its preliminary position paper as its final position paper response in OH CDMS.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to 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.

[1] (Emphasis added.)

The preliminary position paper in the subject appeal, which was due to the Board by August 16, 2019, was filed on August 28, 2019. The applicable regulation and rule provide that the Board is to dismiss an appeal if the Provider does not timely file its position paper. 42 C.F.R. § 405.1868(b) provides:

> 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;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Board Rule 23.4 provides:

> The provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, the case will be dismissed.

The language in the Board Rule is clear that an appeal will be dismissed if a position paper is not timely filed. Moreover, as noted above, the Board warned the Provider in the Acknowledgement and Critical Due Dates Notice that the Board would dismiss the Provider's appeal if the Provider failed to meet any of the due dates given therein (including but not limited to the preliminary position paper due date). Because the Provider's preliminary position paper was received beyond the August 16, 2019 deadline, the Board is exercising its discretion under 42. C.F.R. § 405.1868(b) and hereby dismisses Case No. 19-0531 in accordance with 42 C.F.R. § 405.1868 and Board Rule 23.4.

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

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

FOR THE BOARD

9/30/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Jeffery Reid
Sharp Healthcare
8695 Spectrum Center Blvd.
San Diego, CA 92123 – 1489

RE: Board Own Motion Expedited Judicial Review Determination
Sharp Healthcare Part C Days – DSH Medicaid and Medicare Proxy Groups

17-0730GC	Sharp HC 2005 DHS MC Advantage Days in Medicaid Percentage
13-2436GC	Sharp HC FY 2006 Medicare HMO - Exclusion from Medicare CIRP Group
13-2437GC	Sharp HC FY 2006 Medicare HMO - Inclusion in Medicaid CIRP Group
13-0777GC	Sharp Healthcare 2007 DSH- Exclusion of Dual Eligible Part C Days in Medicaid Percentage CIRP
13-1171GC	Sharp HC 2008 Medicare Advantage Part C Days CIRP Group
14-1493GC	Sharp HC 2009 DSH MC HMO Days in the Medicare Percentage (SSI)
15-1789GC	Sharp HC 2010 DSH MC HMO Days in the Medicare Percentage (SSI)
16-0373GC	Sharp Healthcare 2010 DSH MC HMO Days in the Medicaid Percentage
15-1908GC	Sharp HC FYE 2011 DSH SSI Fraction Medicare Part C HMO Days
16-1859GC	Sharp HC FY 2011 MC HMO Days in the Medicaid Percentage CIRP
15-1681GC	Sharp HC 2012 DSH MC HMO Days in the Medicare Percentage (SSI)
16-2244GC	Sharp HC 2012 Medicaid Eligible MC HMO Days
15-2967GC	Sharp Healthcare 2013 DSH Medicare Advantage Days

Dear Mr. Reid:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the records in the above-referenced appeals. The Board's determination and decision regarding EJR is set forth below.

Issue in Dispute

The issues for which the Board is considering its own motion EJR are:

> ...[Whether] Medicare Advantage days…should be excluded from the Medicare percentage [used to calculate the Provider's allowable disproportionate share hospital (DSH) adjustment payment].[1]

[1] Case No. 13-1171GC, *Model Form B – Group Appeal Request* (Mar. 13, 2013), Tab 2. The Providers use the terms "Medicare Advantage days" or "Medicare HMO days" regarding part C days.

And,

> …[W]hether Medicare Advantage days…should be included in the Medicaid percentage [used to calculate the Provider's allowable DSH payment].[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 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]

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[2] Case No. 13-2437GC, *Model Form B – Group Appeal Request* (Jan. 8, 2013), Tab 2. The Providers use the term "Medicare Advantage days" or "Part C days" regarding part C days.
[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.

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:

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

[11] 42 C.F.R. § 412.106(b)(2)-(3).
[12] Emphasis added.
[13] 42 C.F.R. § 412.106(b)(4).
[14] 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].[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:

> . . . *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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[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.

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

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[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.

Board's Consideration for Own Motion 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 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 I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] 69 Fed. Reg. at 49,099.
[31] *Allina* at 1109.

Jurisdiction for the Group Participants

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005 through 2013.

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

[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, 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 any participant revised NPR appeals included within this EJR were issued after August 21, 2008.

A. Jurisdictional Determination in Case No. 13-2437GC for Participant 3 – Sharp Chula Vista Medical Center, Provider No. 05-0222, FYE 09/30/2006

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,"[38] including documentation relating to jurisdiction. Similarly, the regulations governing group appeals specify that jurisdiction "may be raised at any time."[39]

The Board finds that it does not have jurisdiction over Participant 3, Sharp Chula Vista Medical Center (FYE 09/30/2006), in Case No. 13-2437GC because the issue for this group is challenging the exclusion of Part C Days from the Medicaid percentage and the Provider has appealed from a revised Notice of Program Reimbursement ("NPR") that did not adjust the Medicaid percentage.

The Code of Federal Regulations provides for an opportunity for a revised determination such as a revised NPR. Specifically, 42 C.F.R. § 405.1885 (2016) provides in relevant part:

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

[37] *See* 42 C.F.R. § 405.1889(b)(1) (2008).
[38] 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).
[39] 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."

42 C.F.R. § 405.1889 (2016) explains the effect of a revised determination:

> (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.

Adjustment No. 1 on the Provider's audit adjustment report for the Revised NPR at issue is "To update SSI% and DSH% per CMS data."[40] As this adjustment only pertains to the SSI percentage, there is no adjustment to Part C days in the Medicaid percentage, and because the Medicaid percentage was not specifically adjusted for Part C days, the Board finds that it does not have jurisdiction over Sharp Chula Vista Medical Center's revised NPR appeal in Case No. 13-2437GC because the issue for this case only pertains to the Medicaid percentage.

The Board notes that Sharp Chula Vista Medical Center has a jurisdictionally proper appeal from a revised NPR in Case No. 13-2436GC for Part C days in the Medicare percentage. In that case, the Medicare or SSI percentage was adjusted, the estimated amount in controversy for the group appeal exceeds $50,000 and the appeal was timely filed.

B. Jurisdictional Determination for Remaining Participants

The Board has determined that the remaining participants' appeals involved with the instant EJR are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[41] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the remaining participants.

[40] Schedule of Providers in Case No. 17-0555GC at Tab 1D.
[41] *See* 42 C.F.R. § 405.1837.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2005 through 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[42] 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.[43] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the Own Motion EJR

The Board finds that:

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

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

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

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 its Own Motion EJR for the issue and the subject years for the remaining participants as described above. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

[42] *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).
[43] *See* 42 U.S.C. § 1395oo(f)(1).

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For the Board:

9/30/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.