DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Certified Mail

JUL 0 5 2018

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

RE: **Expedited Judicial Review Determination**

08-0792GC	Catholic Health East 2005 DSH Medicare+Choice Days Group
10-0350GC	Catholic Health East 2007 Medicare Advantage Days Group
12-0375GC	Conemaugh Health System 2010 DSH Medicare Advantage Days CIRP Group
13-1214GC	CHE 2008 DSH Medicare Advantage Days CIRP Group
13-3459GC	SWC CHE 2009 DSH Medicaid Fraction Part C Days CIRP Group
14-2193GC	HCA 2010, 2012 DSH - Medicare Advantage Plan Days CIRP Group
15-0331GC	Southwest Consulting Memorial Hermann 2011 DSH Medicaid Fraction Part C Days CIRP Group
15-0332GC	Southwest Consulting Memorial Hermann 2011 DSH SSI Fraction Part C Days CIRP Group

Dear Mr. Keough:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 25, 2018 request for expedited judicial review (EJR) (received June 26, 2018) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

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

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

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[6] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[12] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[13]

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

With the creation of Medicare Part C in 1997,[15] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[11] 42 C.F.R. § 412.106(b)(4).
[12] of Health and Human Services.
[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [16]

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

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

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[18] In response to a comment regarding this change, the Secretary explained that:

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

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

[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[18] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[19] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[21] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision. More recently in *Allina Health Services v.* Price (*Allina II*),[22] the Court found that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction was vacated by *Allina Health Services* above. The Court found that the Secretary was required to undertake notice and comment ruling-making and the 2012 regulation was invalid. Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The issue under appeal in these cases 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 through 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.[23]

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."[24] 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).

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] 2017 WL 3137976 (D.C. Cir. July 25, 2017).
[23] 69 Fed. Reg. at 49,099.
[24] *Allina* at 1109.

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

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005 and 2007 through 2012.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[25] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[26]

On August 21, 2008, new regulations governing the Board were effective.[27] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[28] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue.

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[25] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[26] *Bethesda at 1258-59.*
[27] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016)

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.[29]

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

For appeals of RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR.[30] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.[31]

For appeals filed from the failure to issue an NPR, providers are not required to demonstrate dissatisfaction in order to preserve their individual rights to a Board hearing.[32]

Case number 14-2193GC includes participants that filed appeals based upon the Medicare Contractor's failure to timely issue an NPR. These participants subsequently filed from receipt of their NPRs. Therefore, Board finds that reaching a decision on these participants' appeals filed from failure to issue a final determination would be futile as the outcome for these Providers would not be affected.

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[29] *Banner* at 142.

[30] *See* 42 C.F.R. § 405.1889(b)(1) (2008).

[31] Case numbers 13-3459GC and 15-0332GC include participants that appealed from revised NPRs. The Board finds that the Providers have jurisdictionally valid appeals pending for the same fiscal year ends from their original NPRs and that reaching a decision on the revised NPR appeals would be futile as the outcome for those Providers would not be affected.

[32] The United States District Court for the District of Columbia issued an order in *Charleston Area Med. Ctr. v. Sebelius*, No. 16-643 (RMC) (D.D.C. filed May 3, 2013) that states that the Board *et al.* are enjoined from applying 42 C.F.R. § 405.1835(a)(1)'s dissatisfaction requirement for Board jurisdiction to any pending or future Board appeal that, pursuant to 42 U.S.C. § 1395oo(a)(1)(B), is based on the Medicare contractor's failure to issue a timely NPR. In the Secretary's responses to the Court's May 27, 2014 and June 10, 2014 Orders to Show Cause, the Secretary made a binding concession that 42 C.F.R. § 405.1835(a)(1)'s requirement that a Medicare provider must establish its "dissatisfaction" by claiming reimbursement for the item in question in its Medicare cost report or by listing the items as a "protested amount" in its cost report, should not apply to Board appeals that are based on the provisions of the Medicare statute, 42 U.S.C. § 1395oo(a)(1)(B), that provide for appeal to the Board where a Medicare contractor does not issue a timely NPR. Subsequently, under 42 C.F.R. § 405.1835(c), CMS codified this change in Board jurisdictional requirements and set an effective date that encompasses Board appeals that were initiated or pending on or after August 21, 2008. *See* 79 Fed. Reg. 49854, 50201 (Aug. 22, 2014). All the Providers' appeals involved in the instant EJR request that were filed based upon the Medicare contractor's failure to issue a timely NPR were initiated or pending on or after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction, or have filed appeals based upon the Medicare Contractor's failure to timely issue an NPR. In addition, the participants' documentation shows that the estimated amount in controversy for the groups exceeds the $50,000 threshold as required for jurisdiction[33] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Decision Regarding the EJR Request

The group appeals in this EJR request span fiscal years 2005 and 2007 through 2012, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject years 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), are valid.

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[33] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD:

Gregory H. Ziegler
Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers

cc: Bruce Snyder, Novitas (Certified w/Schedules)
Byron Lamprecht, Wisconsin Physicians Service (Certified w/Schedules)
Mounir Kamal, Novitas Solutions, Inc. (Certified w/Schedules)
Wilson Leong, Esq., CPA, Federal Specialized Services (w/Schedules)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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JUL 05 2018

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RE: **Expedited Judicial Review Determination**

14-3257GC CHS 2012 DSH SSI Fraction Part C Days Group
14-3260GC CHS 2012 DSH Medicaid Fraction Part C Days Group

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 28, 2018 requests for expedited judicial review (EJR) (received June 29, 2018) for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> number of the hospital's patient days for such period. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> *adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Requests for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[21]

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."[22] 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

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.

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

Decision of the Board

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

Jurisdictional Determination

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

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] 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.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] 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).*[26] 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.

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[23] 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.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)

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.[27]

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

The Board concludes that it lacks jurisdiction over the following Provider in Case Nos. 14-3257GC and 14-3260GC:

Participant #59 – Longview Regional Medical Center (45-0702)

The Provider's NPR is dated December 4, 2014 and the Provider filed a Request to Join An Existing Group: Direct Appeal From Final Determination (Direct Add) on June 9, 2015. This was 187 days from the NPR date.

Pursuant to 42 C.F.R § 405.1801(d)(3), if the last day of the designated time period is a Saturday, a Sunday, a Federal legal holiday (as enumerated in Rule 6(a) of the Federal Rules of Civil Procedure), or a day on which the reviewing entity is unable to conduct business in the usual manner, the deadline becomes the next day that is not one of the aforementioned days. Because June 7th fell on a Sunday, the deadline for any filing requirement due on that day became Monday, June 8th, 2015. This Direct Add was not filed until the following day and is considered late. Therefore, the Board finds it lacks jurisdiction over Longview Regional Medical Center and dismisses the participant from both cases. Since jurisdiction is a prerequisite to granting a request for EJR, the Board hereby denies Longview Regional Medical Center's request for EJR. *See* 42 C.F.R. § 405.1842(a).

The Board has determined that the remaining participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals.[28] In addition, the participants' documentation shows that the estimated

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[27] *Banner* at 142.

[28] On June 27, 2018, the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in PRRB Case Nos. 14-3257G and 13-3260GC. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the

amount in controversy exceeds $50,000, as required for a group appeal[29] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves the fiscal year 2012, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject year and that the participants in these group appeals are entitled to a hearing before the Board except as otherwise noted;

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60

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

[29] *See* 42 C.F.R. § 405.1837.

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

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers

cc: Byron Lamprecht, WPS (Certified Mail w/Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JUL 05 2018

Daniel J. Hettich, Esq.
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RE: **Expedited Judicial Review Determination**
CHS 2010 DSH Medicare + Choice CIRP Group, Case No. 12-0078GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 28, 2018 request for expedited judicial review (EJR) (received June 29, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

> [W]hether CMS unlawfully treats days for which Medicare Part A did not make payment, namely Medicare Advantage days which are paid under Medicare Part C, as days for which patients are entitled to benefits under Medicare Part A for purposes of calculating the Medicare disproportionate share ("DSH") payment.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]

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

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

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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

> number of the hospital's patient days for such period. (emphasis added)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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

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> *adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Requests for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[21]

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."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). In this case, the Providers contend that all Part

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
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C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeal in this EJR request have filed appeals involving fiscal year 2010.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] 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.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] 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).*[26] 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.

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[23] 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.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)

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.[27]

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

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[28] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in this case.

Board's Analysis Regarding the Appealed Issue

The group appeal in this EJR request involves the fiscal year 2010, thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[27] *Banner* at 142.
[28] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject year and that the participants in this group appeal are entitled to a hearing before the Board;

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedule of Providers

cc: Byron Lamprecht, WPS (Certified Mail w/Schedule of Providers)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Certified Mail

JUL 09 2018

Kenneth R. Marcus
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Detroit, MI 48226 3506

RE: **Expedited Judicial Review Determination**
Edward W. Sparrow Hospital, Provider No. 23-0230

Case No. 13-2564	FYE 12/31/2007
Case No. 14-0517	FYE 12/31/2008
Case No. 14-1516	FYE 12/31/2009
Case No. 15-0761	FYE 12/31/2010

Dear Mr. Marcus:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's July 2, 2018 request for expedited judicial review (EJR) (received July 3, 2018) for the above-referenced appeal. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> [W]hether Medicare Advantage Days ("Part C Days")should be removed from the disproportionate share adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C.Cir.2014) ("The Part C Days Issue").[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]
The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

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

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[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[13] *Id.*
[14] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Provider's Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[21]

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."[22] 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 Provider contends 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 Provider seeks a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Provider maintains that, since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.

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 this EJR request has filed appeals involving fiscal years 2007 through 2010.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[23] 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.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] 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).*[26] 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.[27]

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

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[23] 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.).
[24] *Bethesda at 1258-59.*
[25] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016)
[27] *Banner* at 142.

CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that Provider involved with the instant EJR request has a specific adjustment to the SSI fraction, and self-disallowed the issue (case 13-2564) such that the Board has jurisdiction to hear their respective appeals. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000 for each case, as required for an individual appeal[28] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2007 through 2010 cost reporting periods, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) it has jurisdiction over the matter for the subject years and that the Provider 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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[28] *See* 42 C.F.R. § 405.1837.

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are other issues under dispute in these cases, the cases will remain open and scheduled for hearing on December 13, 2018.

Board Members Participating:
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

FOR THE BOARD:

Gregory H. Ziegler

Board Member

Enclosures: 42 U.S.C. § 1395oo(f)

cc: Byron Lamprecht, Wisconsin Physicians Service
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JUL 09 2018

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RE: **Jurisdictional Challenge**
Case Nos: 15-1094GC, 15-1096G, 15-1221GC, 15-1222GC, 15-1223GC, 15-1224GC, 15-1225GC, 15-1226GC, 15-1227GC, 15-1228GC, 15-1229GC, 15-1230GC, 15-1231GC, 15-1232GC, 15-1233GC, 15-1234GC, 15-1235GC, 15-1236GC, 15-1237GC, 15-1238GC, 15-1240GC, 15-1241GC, 15-1242GC, 15-1243GC, 15-1244GC, 15-1245GC, 15-1246GC, 15-1247GC, 15-1248GC, 15-1249GC, 15-1250GC, 15-1251GC, 15-1270GC, 15-1271GC, 15-1272GC, 15-1273GC, 15-1284GC, 15-1285GC, 15-1286GC, 15-1287GC, 15-1288GC, 16-0830GC, 16-0831GC, 16-0832GC, 16-0843GC, 16-0844GC, 16-0851GC, 16-0855GC, 16-0859GC, 16-0860GC, 16-0861GC, 16-0862GC, 16-0863GC, 16-0867GC, 16-0869GC, 16-0870GC, 16-0872GC, 16-0873GC, 16-0874GC, 16-0875GC, 16-0879GC, 16-0880GC, 16-0883GC, 16-0884GC, 16-0885GC, 16-0886GC, 16-0887GC, 16-0888GC, 16-0889GC, 16-0890GC, 16-0891GC, 16-0893GC, 16-0894GC, 16-0899GC, 16-0900GC, 16-0904GC, 16-0906GC, 16-0908GC, 16-0910GC
Providers: Various Akin Gump FFY 2015 and 2016 DSH Uncompensated Care Group Appeals
Provider Nos.: Various
FYEs: 2015 and 2016

Dear Ms. Webster,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the jurisdictional documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On January 28th, 29th and 30th 2015 and January 22, 2016, the Providers in the above-referenced group appeals timely filed group appeal requests with the Board from the August 22, 2014, and August 17, 2015 Final Rules setting forth the federal fiscal year (FFY) 2015 and 2016 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge the procedural and substantive validity of the

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014); 80 Fed. Reg. 49,326, 49515-30 (Aug. 17, 2015). The Provider, Holy Cross Hospital, Provider No. 10-0073, fiscal year end (FYE) 6/30/15, in case number 15-1251GC, filed its appeal from a Notice of Program Reimbursement (NPR). However, the Board approved the addition of the Provider to the fully formed group on October 16, 2017.

Secretary's determinations of their disproportionate share hospital (DSH) payments for uncompensated care costs for FFY 2015 and 2016 and the final rules governing those determinations.

On September 14, 2017, Federal Specialized Services (FSS), on behalf of the Medicare Contractors, filed a Jurisdictional Challenge over the Providers' group appeals arguing that they are not appealable issues and that the Board lacks subject matter jurisdiction over the group appeals. On November 15, 2017, the Providers filed a Jurisdictional Response to the Jurisdictional Challenge.[2]

Medicare Contractor's Position

The Medicare Contractor contends that the Board lacks subject matter jurisdiction based on the statute, 42 U.S.C. § 1395ww(r)(3) and regulation 42 C.F.R. § 412.106(g)(2), which implemented the uncompensated care component that precludes judicial and administrative review. The Medicare Contractor argues the District of Columbia (D.C.) Circuit Court in *Fla. Health Sciences Ctr, Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* (*Tampa General*), 830 F.3d 515 (D.C. Cir. 2016), concluded that preclusion was absolute. The Medicare Contractor maintains that decision when fully considered should dictate the disposition of these 79 group appeals.[3]

The Medicare Contractor asserts the Court in *Tampa General* recognized that the review preclusion was based on sound law and implicit Congressional recognition of what is a very pragmatic problem;[4] the Court found the Providers' attempt to obtain a case by case review for each hospital of its DSH details to be barred by law. The Medicare Contractor requests the Board follow the *Tampa General* decision and dismiss the appeals for lack of subject matter jurisdiction.[5]

Providers' Position

The Providers contend the Secretary's payment determinations of their FFY 2015 and 2016 DSH payments for uncompensated care costs and the final rules governing those determinations are invalid for several reasons, including: 1) the Secretary unlawfully cemented into the new DSH payment the effects of the agency's invalid policy towards the counting of part C Medicare Advantage days in the traditional DSH calculation, 2) the agency inappropriately deflated the Providers' payment amounts by failing to properly and transparently account for the level of Medicaid expansion in estimating DSH payments that would be made for 2015 and 2016 under the traditional DSH payment method (Factor 1) and the national level of uninsured individuals for 2015 (Factor 2) and also failed to properly account for actual enrollment and payments of premiums for coverage under private health plans for FFY 2015 and 2016, 3) the agency denied providers the due process due them and otherwise violated the law by failing to provide them with sufficient information to comment meaningfully on DSH uncompensated care payment determinations and failing to respond adequately to comments that were made,[6] and 4) the Secretary's determinations of the DSH uncompensated care payments are not based on the best, most reliable data available.[7]

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[2] The Medicare Contractors filed prior Jurisdictional Challenges in some of the above-referenced group appeals (i.e. case number 15-1223GC) asserting the same thing, that the issue is not appealable. The Providers responded to those Jurisdictional Challenges. The Board's decision responds to these prior jurisdictional documents as well.
[3] Medicare Contractor's jurisdictional challenge at 2-3.
[4] *Id.* at 4.
[5] *Id.* at 5.
[6] Providers' Group Appeal Request Tab 2 at 3-4.
[7] *Id.* at 5.

The Providers maintain the statute governing the DSH payment for uncompensated care cost[8] does not preclude review of the Secretary's final determinations of the DSH uncompensated care final payment amounts. The Providers assert nor does it preclude review of the regulation[9] fixing the calculation of those payment amounts at the time when the Secretary promulgated the final IPPS rule for 2015 and 2016.[10] The Providers contend the statute only prevents review of select components of the methodology for deriving those final amounts "estimates of the Secretary (for purposes of determining the three factors)" and "periods selected by the Secretary (for those estimates)." The Providers assert the statute does not purport to preclude any review of uncompensated care payment amounts, the methodology used to determine those payment amounts (the data underlying CMS' Factor 1 estimate, CMS' calculation of Factor 2 based on Congressional Budget Office estimates), the underlying rules and regulations governing the determination of the payment amount, or procedural violations committed by the Agency in the rule makings in which the payment amounts were determined or the decision to use inaccurate data to calculate the payment amounts. The Providers argue because the final amount of the Providers' uncompensated care payment was determined by the Secretary prospectively in the final rule, the Medicare Act provides the Providers the right to administrative and judicial review of that payment amount.

The Providers maintain the statutory preclusion of review of certain "estimates of the Secretary" and "periods" selected by the Secretary should not be construed to reach the claims raised in this appeal. The Providers argue their claims challenge neither of the shielded components of the uncompensated care payment, period or estimate. The Providers contend the payment amount, the product of three factors that incorporate estimates, is not an estimate itself and that final determination is not shielded from review. Further, even if the Providers were challenging an estimate of the Secretary, review would still be available to determine whether the estimate was the kind that the Secretary was authorized to make or whether the Secretary has violated his own rules in calculating the Providers' uncompensated care payment.[11]The Providers maintain the language in the relevant preclusion provision allowing for "no administrative or judicial review" means that there is no review of the select, listed items; it does not mean no review at all of anything related to the payment amounts.[12] The Providers contend Congress precluded review of only two components of the DSH payment methodology and not the entire methodology nor the final payment determination;[13] the narrow elements that are shielded from preclusion of review are not at issue here.[14] The Providers argue that the District of Columbia Circuit decision in *Tampa General* involves different claims than in its appeals.[15]

Board's Decision

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

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[8] 42 U.S.C. § 1395ww(r)(3).
[9] 42 C.F.R. § 412.106(g).
[10] Providers' Group Appeal Request Tab 2 at 5-6; Providers' Consolidated Response to Jurisdictional Challenge at 2.
[11] Providers' Consolidated Response to Jurisdictional Challenge at 17.
[12] *Id.* at 2, 15-16.
[13] *Id.* at 22.
[14] *Id.* at 24.
[15] *Id.* at 21.

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[16]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[17] upheld the D.C. District Court's decision[18] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued (similar to the Providers in these group appeals) that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[19] The Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[20]

The Court also found *Tampa General's* argument (similar to the arguments made in these group appeals) that the statute creates no bar to a court reviewing the Secretary's ultimate decision as to the amount of a hospital's final DSH payment, but only the intermediate determination as to the estimate of a hospital's share of uncompensated care unpersuasive. The Court noted that this is a distinction without a difference. The Court stated the critical factor is not whether the statute barred from review the agency's ultimate determination or merely an intermediate step in reaching that decision. Rather, the Court found the dispositive issue is whether the challenged data are inextricably intertwined with an action that all agree is shielded from review, regardless of where that action lies in the agency's decision tree. The Court noted because the data is inextricably intertwined with the Secretary's estimate of uncompensated care, *Tampa General* cannot challenge the Secretary's choice of data in court.[21]

Further, the Court found *Tampa General's* argument (similar to the arguments made in these group appeals) that the bar should be read narrowly because Congress shielded from judicial challenge only

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[16] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).

[17] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).

[18] 89 F. Supp. 3d 121 (D.D.C. 2015).

[19] 830 F.3d 515, 517.

[20] *Id.* at 519.

[21] *Id.* at 521.

two components of HHS' methodology--the estimates and periods--rather than the entire methodology or the ultimate determination unconvincing. The Court noted even viewing the bar narrowly, the selection of data fit squarely within it. The data and the estimate are so closely intertwined that it could not review either.[22]

In addition, the Court was not persuaded by *Tampa General's* argument (similar to the arguments made in these group appeals) in which it sought to reframe its challenge as an attack on something other than an estimate by the Secretary. *Tampa General* asserted that the Court should construe its complaint as a challenge to HHS' general rules leading to the estimate rather than as a challenge to the estimate itself. The Court found *Tampa General* had not brought a challenge to any general rules leading to the Secretary's estimate. The Court noted that *Tampa General* was simply trying to undo the Secretary's estimate of the hospital's uncompensated care by recasting its challenge to the Secretary's choice of data as an attack on the general rules leading to her estimate.[23]

The Board finds that the same findings are applicable to the Providers' challenge to its 2015 and 2016 uncompensated care payments. The Providers attempt to distinguish their appeals from the facts in *Tampa General*, but they do not do so successfully.

Although the Providers here are challenging additional parts of the uncompensated care calculation (Part C days and Medicaid expansion) than in *Tampa General*, they are still challenging the underlying data. The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation.

As the uncompensated care DSH issue is the only issue in these appeals, the above-referenced group appeals are hereby closed and removed from the Board's docket.[24]

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD

Charlotte F. Benson

Charlotte F. Benson, CPA
Board Member

cc: Wilson Leong, Federal Specialized Services
Mounir Kamal, Novitas Solutions, Inc.
Pam VanArsdale, National Government Services, Inc.
Cecile Huggins, Palmetto GBA
Byron Lamprecht, Wisconsin Physicians Service
Geoff Pike, First Coast Service Options, Inc.
Danene Hartley, National Government Services, Inc.
Laurie Polson, Palmetto GBA

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[22] *Id.*
[23] *Id.* at 521-22.
[24] As the appeals are being dismissed in their entirety on subject matter jurisdiction, the Board is not attaching the schedule of providers for each group appeal to the decision.

Bruce Snyder, Novitas Solutions, Inc.
Lorraine Frewert, Noridian Healthcare Solutions, LLC
John Bloom, Noridian Healthcare Solutions, LLC
Judith Cummings, CGS Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

CERTIFIED MAIL

JUL 2 0 2018

David M. Johnston
Bricker & Eckler LLP
100 S. Third Street
Columbus, OH 43215

RE: Marion General Hospital, 36-0011, FYE 6/30/2014, Case No. 16-2493
Grant Medical Center, 36-0017, FYE 6/30/2014, Case No. 17-0195
Dublin Methodist Hospital, 36-0348, FYE 6/30/2014, Case No. 17-0197
Riverside Methodist Hospital, 36-0006, FYE 6/30/2014, Case No. 17-0659
MedCentral Health System (Mansfield), 36-0118, FYE 12/31/2014, Case No. 17-1910
Doctor's Hospital, 36-0152, FYE 6/30/2014, Case No.18-0344

Dear Mr. Johnston:

The Provider Reimbursement Review Board (the Board) has begun a review of the above-captioned individual appeals. We note that each of the commonly owned/controlled Providers listed appealed from a Notice of Program Reimbursement (NPR) for a 2014 cost reporting period. The NPRs were issued to include the most recent SSI percentage that was recalculated by the Centers for Medicare and Medicaid Services ("CMS") (post-2011 Final Rule with new data matching). All of the Providers, except Doctor's Hospital (Case No. 18-0344) have included the SSI Realignment issue in their individual appeals. The specific facts with regard to the issues in the individual appeals and the Board's determination are set forth below.

SSI Provider Specific Issue

One of the issues in the individual appeals (except case number 18-0344) is the *Use of Provider's Cost Report Year for Calculation of DSH Percentage (SSI Realignment).*[1] The Providers are appealing their right to request realignment of the SSI percentage from the federal fiscal year to the hospital's cost reporting period. The Board finds it lacks jurisdiction and dismisses this issue from the individual appeals. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

[1] The Board notes that each of the Providers also appealed the *Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage* issue directly, or transferred the issue, into a common issue related party (CIRP) group, the OhioHealth Corporation 2014 SSI Percentage CIRP Group (Case No. 17-0201GC).

Bad Debts (Indigence Determination) Issue

The Providers in case numbers 17-1910, 17-0659, 17-0195 and 18-0344 appealed the Medicare Contractor's disallowance of a portion of the Providers' bad debt expenses for outpatient services claimed as a result of patient indigence based on alleged improper indigence determinations. Because this issue is common to four of the Providers in the OhioHealth chain and the amount in controversy meets the $50,000 threshold, the Providers are required to pursue this issue in the group appeal format.[2] Consequently, the Board has established a new group appeal for the Bad Debts (Indigence Determination) issue. Enclosed, please find the Board's Acknowledgement letter for the new group. Within 30 days, please advise whether the group is fully formed.

Bad Debts (Inconsistent Collection Efforts) Issue

The Providers in case numbers 16-2493, 17-0195, 17-0197, 17-0659 and 18-0344 also appealed the Medicare Contractor's disallowance of the Providers' claimed bad debts that were sent to an outside collection agency because of alleged improper collection and billing practices. As indicated above, because this issue is common to OhioHealth Providers and totals over $50,000, it is required to be pursued as a group appeal. The Board has established a new group appeal for the Bad Debts (Inconsistent Collection Efforts) issue. Enclosed, please find the Board's Acknowledgement letter for the new group. Within 30 days, please advise whether the group is fully formed.

After the dismissal of the SSI Realignment issue and the transfer of the two bad debts issues, there are no remaining issues in all six individual appeals. Therefore the Board is closing case numbers 16-2493, 17-0195, 17-0197, 17-0659, 17-1910 and 18-0344 and removing them from the docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.

FOR THE BOARD

Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
Group Acknowledgement Letters

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

[2] 42 C.F.R. 405.1837(b). 10/01/2015

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Certified Mail

JUL 2 4 2018

Elizabeth A. Elias
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Indianapolis, IN 46204

RE: EJR Request
Hall Render FFY 2018 ATRA/MACRA 0.7% D&C Adjustment Groups
PRRB Case Nos.: See Attached List

Dear Ms. Elias:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' July 6, 2018 request for expedited judicial review ("EJR Request") (received July 9, 2018) for the cases on the attached list. The decision of the Board is set forth below.

Issue in Dispute

The Providers are challenging:

> [W]hether [the Centers for Medicare & Medicaid Services' ("CMS")] miscalculated the [Documentation and Coding ("D&C")] Adjustment for FY 2018 and exceeded its statutory authority by refusing to restore the 0.7% Adjustment, thereby violating the Administrative Procedures Act ("APA"), which prohibits agency action that is not in accordance with law, 5 U.S.C. § 706(2)(A), or that is in excess of statutory jurisdiction, authority or limitations, or short of statutory right. 5 U.S.C. § 706(2)(C).[1]

Statutory and Regulatory Background

In the federal fiscal year ("FFY") 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 encourage hospitals to improve their documentation and coding of patient diagnoses.[4]

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[1] Providers' July 6, 2018 EJR Request at 1.
[2] 72 FR 47,130, 47140 through 47189 (Aug. 22, 2007).
[3] of the Department of Health and Human Services.
[4] 81 Fed. Reg. 56,762, 56,780 (Aug. 22, 2016).

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 (Public Law 110–90) ("TMA"). Section 7(a) of this statute 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.[6]

The Secretary implemented a series of adjustments required under sections 7(b)(1)(A) and 7(b)(1)(B) of the TMA, based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013, but indicated in the FY 2013 IPPS/LTCH [Long Term Care Hospital] PPS final rule that delaying full implementation of the adjustment required under section 7(b)(1)(A) of the TMA until FY 2013 resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[7]

Section 631 of the American Tax Payer Relief Act of 2012 ("ATRA") amended section 7(b)(1)(B) of the TMA to require the Secretary to make a recoupment adjustment or adjustments totaling $11 billion by FY 2017. This adjustment represented the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under section 7(b)(1)(A) of the TMA until FY 2013. As discussed above, this delay in implementation resulted in overstated payment rates in FYs 2010, 2011, and 2012. The resulting overpayments could not have been recovered under the TMA.

The adjustment required under section 631 of the ATRA 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 2018, once the necessary amount of overpayment was recovered. However, section 414 of the Medicare Access and CHIP Reauthorization Act ("MACRA") of 2015, Public Law 114–10, replaced the single positive adjustment that the Secretary intended to

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[5] 82 Fed. Reg. 37,990, 38,008 (Aug. 17, 2017).
[6] *Id.*
[7] 82 Fed. Reg. at 38,008.

make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. However, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), reduced the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points. [8]

The Secretary's actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if the Secretary was to fully recover the $11 billion recoupment required by section 631 of the ATRA in FY 2014. It is often the Secretary's practice to phase in payment rate adjustments over more than one year, in order to moderate the effect on payment rates in any one year. Therefore, consistent with the policies that the Secretary adopted in many similar cases, the Secretary implemented a -0.8 percentage point recoupment adjustment to the standardized amount in FY 2014. The Secretary estimated that if adjustments of approximately -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, the entire $11 billion would be accounted for by the end of the statutory 4-year timeline.[9]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by section 631 of the ATRA, in the FY 2015 IPPS/LTCH PPS final rule[10] and the FY 2016 IPPS/LTCH PPS final rule,[11] 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 section 631 of the ATRA by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[12] 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 section 631 of the ATRA. For the FY 2017 IPPS/LTCH PPS final rule,[13] 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 section 631 of the ATRA.[14]

Once the recoupment required under section 631 of the ATRA was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA. However, section 414 of the MACRA (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

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[8] *Id.*
[9] *Id.*
[10] 79 Fed. Reg. 49,326, 49,874 (Aug. 24, 2014).
[11] 80 Fed. Reg. 49,326, 49345 (Aug. 17, 2015).
[12] 81 Fed. Reg. 24,946, 24966 (Apr. 7, 2016).
[13] *Id.*
[14] 82 Fed. Reg. at 38,008-9.

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, section 15005 of the 21st Century Cures Act (Pub. L. 114–255), which was enacted on December 13, 2016, amended section 7(b)(1)(B) of the TMA, as amended by section 631 of the ATRA and section 414 of the MACRA, to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes that the directive under section 15005 of the Public Cures Act is clear. Therefore, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point adjustment to the standardized amount. This is a permanent adjustment to payment rates.[15]

The FY 2018 Federal Register (August 14, 2017)

The Federal Register comments to the FY 2018 Final IPPS Rule, included the following:

> Several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under section 631 of the ATRA, 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 CMS to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018; that is, 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.** Commenters also urged CMS to use its discretion under section 1886(d)(5)(I) of the Act 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 section 631 of the ATRA be returned.
>
> *Response:* As discussed in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56783 through 6785), CMS completed the $11 billion recoupment required under section 631 of the ATRA. We continue to disagree that section 414 of the MACRA was intended to augment or limit our separate obligation under the ATRA to fully offset $11 billion by FY 2017, as we discussed in response to comments in the FY 2017 IPPS/LTCH PPS final rule (81 FR 56784). Moreover, as we discussed in the FY 2018 IPPS/LTCH PPS proposed rule, we believe the directive regarding the applicable adjustment for FY 2018 is clear. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA requires that we not make the single positive adjustment we

[15] *Id.* at 38009.

> intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. 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, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Finally, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under section 631 of the ATRA in the FY 2017 rulemaking.
>
> After consideration of the public comments we received, we are finalizing the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under section 15005 of Public Law 114–255. (emphasis added)[16]

Providers' Request for EJR

Within its EJR Request, the Providers contend that the Secretary's refusal to restore the additional 0.7 percent ATRA reduction in the FFY 2018 IPPS Final Rule violates the Administrative Procedures Act and that "CMS was never authorized to impose a permanent negative adjustment beyond FY 2017."[17] The Providers believe that the Secretary erroneously concluded that the additional 0.7 percent ATRA reduction was intended to continue under MACRA and the 21st Century Cures Act. In reaching this conclusion, the Secretary stated that he lacked discretion to adopt any other position because "the directive regarding the applicable adjustment for FY 2018 is clear."[18] Therefore, the Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for 2018, as required by section 15005 of the 21st Century Cures Act.

The Providers argue that, in 2015, Congress passed MACRA which amended that TMA Act and replaced the single positive adjustment that CMS was to make in 2018 with a positive 0.5% adjustment for each year between FY 2018 and FY 2023, for a total offsetting positive adjustment of 3.0%. The Providers assert that per MACRA, Congress based this 0.5% phase-in adjustment on the understanding that the single positive adjustment was "estimated to be an increase of 3.2 percent."[19] Thus, the Providers argue, Congress contemplated a total decrease of approximately 0.2% in the positive adjustment offset at time of MACRA (an actual phased-in positive adjustment of 3.0% as compared to the single positive 3.2% adjustment contemplated by CMS and acknowledged by Congress in MACRA).

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[16] 82 Fed. Reg. at 38009.
[17] EJR Request at 1-2.
[18] 82 Fed. Reg. at 38009.
[19] Section 7(b)(1)(B) of the TMA Act.

Subsequently, on August 22, 2016, CMS promulgated its FY 2017 IPPS Final Rule and determined that it needed to impose the 0.7% Adjustment in 2017, thereby imposing a total negative adjustment of 3.9%.

Congress passed the 21st Century Cures Act (Pub. L. 114-255), which further amended the TMA Act and replaced the positive 0.5% adjustment in FY 2018 with a positive adjustment of 0.4588%, though it retained the other positive adjustments through FY 2023. The Providers point out that Congress did not amend the language of the TMA Act included via MACRA that estimated CMS' total negative adjustment as 3.2%. The Providers claim that CMS was directed to restore 3.0 percentage points of the 3.2 percentage point cut that was implemented between FY 2014-2017 and that Congress did not account for, nor did it direct CMS to retain, the 0.7% Adjustment via the Cures Act.

Decision of the Board

The Board concludes that it lacks the authority to grant the relief sought by the Providers, to apply a positive adjustment of 0.7 percent to the IPPS standard amount. Consequently, the Board hereby grants the Providers' EJR Request for the issue and FFY 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 timely filed appeals of the August 14, 2017 Federal Register notice[20] and the amount in controversy exceeds the $50,000 threshold for jurisdiction over each group.[21] 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

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[20] 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.

[21] *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 IPPS standardized amount, is valid.

Accordingly, the Board finds that the question of the validity of the 0.7 percent reduction to the IPPS rate 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, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

Gregory H. Ziegler
Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers, List of Cases

cc: Laurie Polson, Palmetto GBA c/o NGS (Certified Mail w/ Schedules of Providers)
Pam VanArsdale, NGS (Certified Mail w/ Schedules of Providers)
Judith E. Cummings, CGS Administrators (Certified Mail w/ Schedules of Providers)
Danene Hartley, NGS (Certified Mail w/ Schedules of Providers)
Byron Lamprecht, WPS Government Health Administrators (Certified Mail w/ Schedules of Providers)
Mounir Kamal, Novitas Solutions (Certified Mail w/ Schedules of Providers)
John Bloom, Noridian Healthcare Solutions (Certified Mail w/ Schedules of Providers)
Cecile Huggins, Palmetto GBA (Certified Mail w/ Schedules of Providers)
Bruce Snyder, Novitas Solutions (Certified Mail w/ Schedules of Providers)
Geoff Pike, First Coast Service Options, Inc. (Certified Mail w/ Schedules of Providers)
Wilson Leong, FSS (w/Schedules of Providers)

EXHIBIT EJR-1

LIST OF PROVIDERS AND CASES

PRRB Case Number	Case Name
18-0549GC	Bayhealth Medical Center FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0571GC	Avera Health FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0572GC	Allegheny Health Network FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0573GC	Cone Health FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0605GC	Huntsville Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0606GC	Franciscan Alliance FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0607GC	Covenant Health FFY 2018 ATRA/MACRA .7% D%C Adjustment CIRP Group
18-0608GC	Orlando Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0609GC	Regional Medical Center FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0628GC	Unity Point Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0631GC	Aspirus FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0636GC	Upper Allegheny Health System FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0637GC	Aurora Health Care FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0649GC	Froedtert FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0652GC	Hartford HealthCare FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0654GC	Sanford Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0657GC	Advocate Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0707GC	CarePoint Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0708GC	Infirmary Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0709GC	Temple University Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0710GC	Sinai Health System FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group

18-0717GC	Community Health Network FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0720GC	Rochester Regional Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0721GC	Asante Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0722GC	ProHealth Care FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0725GC	Westchester Medical Center Health Network FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0727GC	Indiana University Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0728GC	St. Elizabeth Healthcare FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0729GC	OSF Healthcare System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0732GC	LCMC Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0734GC	West Tennessee Healthcare System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0738GC	Methodist Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0739GC	Lehigh Valley Health Network FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0740GC	Premier Health Partners FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0741GC	McLaren Health Care FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0742GC	MidMichigan Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0743GC	Genesis Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0744GC	Mayo Clinic FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0745GC	Thomas Health System FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0746GC	PeaceHealth FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0751GC	INTEGRIS Health FFY 2018 ATRA/MACRA .7% D&C Adjustment
18-0752GC	Deaconess Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0753GC	University of Rochester MC FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0754GC	WakeMed Health & Hospitals FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0756GC	Samaritan Health Services FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0758GC	Atlantic Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group

18-0760GC	Roper St. Francis Healthcare System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0762GC	Tanner Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP group
18-0763GC	Northwestern Memorial HealthCare FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0765GC	Sisters of Charity Leavenworth Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0767GC	Greenville Hospital System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0769GC	Rush Health System FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group
18-0770GC	Riverside Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0772GC	Baptist Health - AR FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0785GC	Ascension Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0786G	Hall Render FFY 2018 ATRA/MACRA .7% D&C Adjustment Group III
18-0788GC	Ballad Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0790GC	Kettering Health Network FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0792GC	Steward Health Care System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0799GC	Penn Medicine FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0801GC	UPMC FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0802GC	Henry Ford Health System FFY 2018 ATRA/MACRA .7% D&C Adjustment
18-0803GC	Community Healthcare System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0804GC	Inspira Health Network FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0805GC	Mercy Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0818G	Hall Render FFY 2018 ATRA/MACRA .7% D&C Adjustment Group I
18-0819G	Hall Render FFY 2018 ATRA/MACRA .7% D&C Adjustment Group II
18-0820GC	Carolinas Healthcare System FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0821GC	Spectrum Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0822GC	Parkview Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0823GC	Edward-Elmhurst Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0824GC	Beaumont Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0826GC	Beacon Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0828GC	Vidant Health FFY 2018 ATRA MACRA .7% D&C Adjustment CIRP Group

18-0832GC	Baptist Health (KY) FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group
18-0908GC	Northwell Health FFY 2018 ATRA/MACRA .7% D&C Adjustment CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

CERTIFIED MAIL

JUL 24 2018

Hall, Render, Killian, Heath & Lyman
Maureen O'Brien Griffin
500 North Meridian Street
Suite 400
Indianapolis, IN 46204

RE: **Jurisdictional Determination Hall Render DSH SSI Post 1498R Data Match Groups**

13-0184GC	Lifepoint 2007 DSH SSI Data Match CIRP Group
13-0185GC	LifePoint 2008 DSH SSI Data Match CIRP Group
13-1170G	Hall Render 2007 Post 1498R DSH SSI Data Match Optional Group
13-1446G	Hall Render 2008 Post 1498R DSH SSI Data Match Optional Group
13-1803G	Hall Render 2006 DSH SSI Post 1498-R Data Match Group
13-1942GC	Advocate Health Care 2006 DSH – SSI Post 1498-R Data Match CIRP Group
13-1967GC	McLaren Health Care 2007-2008 DSH SSI Post 1498R Data Match CIRP Group
13-1990GC	Advocate Health Care 2007 DSH – SSI Post 1498-R Data Match CIRP Group
13-2045GC	Franciscan Alliance 2007 DSH – SSI Post 1498R Data Match CIRP Group
13-2055GC	Franciscan Alliance 2008 DSH – SSI Post 1498R Data Match CIRP Group
13-2154GC	Lifepoint 2010 DSH SSI Data Match CIRP Group
13-2188GC	Franciscan Alliance 2006 DSH – SSI Post 1498R Data Match CIRP Group
13-2203GC	Community Health Network 2006 DSH Post 1498R SSI Data Match CIRP Group
13-2285G	Hall Render 2009 DSH SSI Post 1498-R Data Match Group
13-2525GC	Community Health Network 2009 DSH Post 1498R Data Match CIRP Group
13-2588GC	Capella Healthcare 2008 SSI Post 1498R Data Match CIRP Group
13-2626GC	Community Healthcare System 2008 DSH Post 1498R Data Match CIRP Group
13-3077GC	Cook County Chicago 2007 SSI Post 1498R Data Match CIRP Group
13-3133GC	Valley Health 2006 DSH SSI Post 1498R Data Match CIRP Group
13-3404GC	Community Healthcare System 2009 DSH Post 1498R Data Match CIRP Group
14-0648G	Hall Render 2010 Post 1498R DSH Data Match Group
14-1037G	Hall Render 2011 Post 1498R DSH Data Match Group
14-3288G	Hall Render 2012 DSH SSI Data Match Group
15-1671G	Hall Render 2011 Post 1498R DSH Data Match Group II
15-1866G	Hall Render 2013 DSH SSI Data Match Group
15-2538G	Hall Render 2010 Post 1498R DSH Data Match Group II
15-2641G	Hall Render 2012 Post 1498R DSH Data Match Group II
15-2717G	Hall Render 2008 Post 1498R DSH SSI Data Match Optional Group II
15-3403G	Hall Render 2009 Post 1498R DSH SSI Data Match Optional Group II
16-1520G	Hall Render 2011 Post 1498R DSH Data Match Group III
13-1487GC	Truman 2007 SSI Days CIRP Group
13-3656GC	Truman 2008 SSI Days CIRP Group

13-3843GC Truman Medical Center 2010 SSI Days CIRP Group

Dear Ms. Griffin,

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

Background

All of the Hall Render DSH SSI Post 1498R Data Match groups under appeal filed a Joint Scheduling Order with the Board on May 30, 2017. The Providers filed a combined Final Position Paper on March 30, 2018. A live hearing was scheduled for July 18 and 19, 2018. The issue statement is stated as follows:

> The days at issue in these group appeals are the days of care the Providers provided to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits in the month they received services. The issue presented in these appeals is whether the Providers' Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations were understated due to the Centers for Medicare and Medicaid Services' ("CMS") and the MAC's failure to include all patients who were entitled to Medicare and SSI benefits ("SSI Patient days") in the numerator of the Medicare fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi), because CMS failed to identify all appropriate SSI Patient days in matching Medicare programs records with SSI program records maintained by the Social Security Administration.

The following group appeals were adjudicated in PRRB Decision 2017-D11 – Hall Render Optional and CIRP DSH/SSI Eligible Group Appeals – Medicare Fraction:

- 13-0172GC – Lifepoint 2007 Medicare Fraction Dual Eligible Days CIRP Group
- 13-0174GC – Lifepoint 2008 Medicare Fraction Dual Eligible Days CIRP Group
- 13-0885G – Hall Render 2007 DSH Medicare Fraction Dual Eligible Days Group
- 13-1764G – Hall Render 2008 DSH Medicare Fraction Dual Eligible Days Group
- 13-1872G – Hall Render 2006 DSH SSI Ratio Dual Eligible Days Group
- 13-1862GC – Advocate Health Care 2006 DSH SSI Dual Eligible Days CIRP Group
- 13-2081GC – McLaren Health Care 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
- 13-2076GC – Advocate Health Care 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
- 13-2049GC – Franciscan Alliance 2007 DSH Medicare Fraction Dual Eligible Days CIRP Group
- 13-2066GC – Franciscan Alliance 2008 DSH Medicare Fraction Dual Eligible Days CIRP Group
- 13-2190GC – Franciscan Alliance 2006 2006 DSH SSI Fraction Dual Eligible Days

CIRP Group
- 13-2223GC – Community Health Network 2006 DSH SSI Fraction 2006 Dual Eligible Days CIRP Group
- 13-2298G – Hall Render 2009 DSH Medicare Fraction Dual Eligible Days Group
- 13-2488GC – Community Health Network 2009 Medicare Fraction Dual Eligible Days CIRP Group
- 13-2574GC – Capella Healthcare 2008 DSH Medicare Ratio Dual Eligible Days CIRP Group
- 13-2627GC – Community Healthcare System 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
- 13-3082GC – Cook County Chicago 2007 Medicare Fraction Dual Eligible Days CIRP Group
- 13-3137GC – Valley Health 2006 DSH Medicare Fraction Dual Eligible Days
- 13-3402GC – Community Healthcare System 2009 DSH Medicare Fraction Dual Eligible Days CIRP Group

The issue in those group appeals was stated as follows:[1]

> Whether the Medicare Disproportionate Share Hospital ("DSH") reimbursement calculations for the Providers ("Hospitals") were understated due to the failure of the Centers for Medicare and Medicaid Services ("CMS") and the relevant Medicare Administrative Contractors ("Medicare Contractors") to include all supplementary security income ("SSI") eligible patient days in the numerator of the Medicare fraction of the Medicare DSH percentage as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The following group appeals were granted Expedited Judicial Review (EJR) on June 1, 2018:

- 13-2160GC - LifePoint 2010 DSH Medicare Fraction Dual Eligible Days Group
- 14-0650G - Hall Render 2010 DSH Medicare Fraction Dual Eligible Days Group
- 14-1022G - Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group
- 14-3286G - Hall Render 2012 DSH SSI Ratio Dual Eligible Days Group
- 15-1672G - Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group II
- 15-1876G - Hall Render 2013 DSH SSI Fraction Dual Eligible Days Group
- 15-1869G - Hall Render 2010 DSH SSI Fraction Dual Eligible Days Group II
- 15-2644G - Hall Render 2012 DSH SSI Fraction Dual Eligible Days Group II
- 15-1024G - Hall Render 2008 DSH Medicare Fraction Dual Eligible Days Group II
- 15-2256G - Hall Render 2009 SSI Fraction Dual Eligible Days Group II
- 16-1522G - Hall Render 2011 DSH Medicare Fraction Dual Eligible Group III

[1] The issue in PRRB Decision 2017-D12 – Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction was identical.

The issue in those group appeals was stated as follows:

> Whether the Provider's Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' (MACs') failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[2]

Analysis

The Board finds that the issue as described in the Hall Render DSH SSI Post 1498R Data Match Group Appeals is virtually the same as the issue in the SSI Fraction Dual Eligible Days Group Appeals that were adjudicated in PRRB Decisions 2017-D11 and 2017-D12 or granted EJR on June 1, 2018.

The Board finds that the arguments in the Hall Render DSH SSI Post 1498R Data Match Group Appeals are similar to the arguments in the Hall Render SSI Fraction Dual Eligible Days Group Appeals adjudicated in PPRB Decisions 2017-D11 and 2017-D12, and those granted EJR on June 1, 2018. The Groups argue that CMS has not given it access to the Social Security Administration's (SSA) data necessary to ensure that all SSI entitled days were included in the numerator of the DSH calculation. They argue that several SSI Program Status Codes were omitted from the CMS published SSI percentages and that they should be able to use their own dual eligible days data as the best available data to ensure that the SSI percentages are accurately calculated. Additionally they argue that SSI benefits are a form of financial insurance and the term entitled to SSI must be interpreted the same as entitled to Medicare Part A benefits. Finally, they argue that beneficiaries with an E01 code receive Medicare Part D Extra Help subsidy payments and are SSI entitled, even if SSI stipend is lost, but the Extra Help subsidy continues. The Providers point out that CMS doesn't use this code in its matching process.

The Board performed a comparison of the Schedules of Providers for the Hall Render DSH SSI Post 1498R Data Match Group Appeals and the Hall Render SSI Fraction Dual Eligible Days Group Appeals. With the exception of the following, the participants in the SSI Data Match groups also were also included in the SSI Fraction Dual Eligible Days Groups previously adjudicated:

- PRRB Case No. 13-1170G – Hall Render 2007 Post 1498R DSH SSI Data Match Optional Group – Caldwell Memorial Hospital PN 34-0041 FYE 9/30/07 and Community Howard Regional Health PN 15-0007 FYE 12/31/07 included therein but not in the corresponding dual eligible days case – 13-0885G - Hall Render 2007 DSH Medicare Fraction Dual Eligible Days Group.

[2] Providers' EJR Request at 2.

- PRRB Case No. 13-1446G - Hall Render 2008 Post 1498R DSH SSI Data Match Optional Group - Caldwell Memorial Hospital PN 34-0041 FYE 9/30/08 included therein but not in the corresponding dual eligible days case – 13-1764G - Hall Render 2008 DSH Medicare Fraction Dual Eligible Days Group; University of Virginia Medical Center PN 49-0009 FYE 6/30/08 was included in PRRB Decision 2017-D12.

- PRRB Case No. 13-1803G - Hall Render 2006 DSH SSI Post 1498-R Data Match Group - Caldwell Memorial Hospital PN 34-0041 FYE 9/30/06 and WakeMed Health & Hospitals PN 34-0173 FYE 9/30/06 included therein but not in the corresponding dual eligible days case – 13-1872G - Hall Render 2006 DSH SSI Ratio Dual Eligible Days Group.

- PRRB Case No. 13-1967GC - McLaren Health Care 2007-2008 DSH SSI Post 1498R Data Match CIRP Group – McLaren-Macomb PN 23-0227 FYE 9/30/08 included therein but corresponding PRRB Case No. 13-2081GC – McLaren Health Care 2007 DSH SSI Fraction Dual Eligible Days CIRP Group was not expanded to include FYE 9/30/08 for this Provider.

- PRRB Case No. 13-2285G - Hall Render 2009 DSH SSI Post 1498-R Data Match Group – St. Mary's Medical Center of Evansville PN 15-0100 FYE 6/30/09, Jamaica Hospital Medical Center PN 33-0014 FYE 12/31/09, Caldwell Memorial Hospital PN 34-0041 FYE 9/30/09, and Weirton Medical Center PN 51-0023 FYE 6/30/09 included therein but not in the corresponding dual eligible days case – 13-2298G - Hall Render 2009 DSH Medicare Fraction Dual Eligible Days Group; University of Virginia Hospital PN 49-0009 FYE 6/30/09 was included in PRRB Decision 2017-D12.

- PRRB Case No. 14-0648G – Hall Render 2010 Post 1498R DSH SSI Data Match Group – Nicholas H. Noyes Memorial Hospital PN 33-0238 FYE 12/31/10 and Weirton Medical Center PN 51-0023 FYE 6/30/10 included therein but not in the corresponding dual eligible days case – 14-0650G – Hall Render 2010 DSH Medicare Fraction Dual Eligible Days Group; Nicholas H. Noyes Memorial Hospital was included in PRRB Case No. 15-1869G – Hall Render 2010 DSH SSI Fraction Dual Eligible Days Optional Group II.

- PRRB Case No. 15-1671G – Hall Render 2011 Post 1498R SSI Data Match Optional Group II – Thomas Memorial Hospital PN 51-0029 FYE 9/30/11 included therein but not in the corresponding dual eligible days case – 15-1672G – Hall Render 2011 DSH SSI Fraction Dual Eligible Days Optional Group II.

- PRRB Case No. 15-2538G – Hall Render 2010 DSH Post 1498R SSI Data Match Optional Group II – Thomas Memorial Hospital PN 51-0029 FYE 9/30/10 included therein but not in the corresponding dual eligible days case – 15-1869G – Hall Render DSH SSI Fraction Dual Eligible Days Optional Group II.

- PRRB Case No. 15-2641G – Hall Render 2012 DSH Post 1498R SSI Data Match Optional Group II – Thomas Memorial Hospital PN 51-0029 FYE 9/30/12 included

therein but not in the corresponding dual eligible days case – 15-2644G – Hall Render 2012 DSH SSI Fraction Dual Eligible Days Optional Group II.

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 Board notes that Board Rule 4.5 states that a Provider may not appeal an issue from a final determination in more than one appeal. As such, the Board dismisses PRRB Case Nos. 13-0184GC, 13-0185GC, 13-1942GC, 13-1990GC, 13-2045GC, 13-2055GC, 13-2154GC, 13-2188GC, 13-2203GC, 13-2424GC, 13-2588GC, 13-2626GC, 13-3077GC, 13-3133GC, 13-3404GC, 14-1037G, 13-3288G, 15-1866G, 15-2717G, 15-3403G, and 16-1520G in their entirety and removes them from the Board's docket, as all of the Providers included in the groups were also included in the SSI Fraction Dual Eligible Days group appeals wherein the Dual Eligible/SSI data issue was previously adjudicated.

Using the same rationale, the Board addresses the nine remaining DSH SSI Post 1498R Data Match groups as follows:

- Dismisses all of the Providers in PRRB Case No. 13-1170G with the exception of Caldwell Memorial Hospital PN 34-0041 FYE 9/30/07 and Community Howard Regional Health PN 15-0007 FYE 12/31/07.
- Dismisses all of the Providers in PRRB Case No. 13-1446G after moving Caldwell Memorial Hospital PN 34-0041 FYE 9/30/08 to PRRB Case No. 13-1170G, and removes the case from the Board's docket.
- Dismisses all of the Providers in PRRB Case No. 13-1803G with the exception of Caldwell Memorial Hospital PN 34-0041 FYE 9/30/06 and WakeMed Health & Hospitals PN 34-0173 FYE 9/30/06. The Board consolidates CN 13-1803G into PRRB Case No. 13-1170G. The Board renames Case No. 13-1170G as Hall Render 2006-2008 Post 1498R DSH SSI Data Match Optional Group.
- Dismisses all of the Providers in PRRB Case No. 13-1967GC after moving McLaren-Macomb PN 23-0227 FYE 9/30/08 back to an individual appeal, and removes the case from the Board's docket.
- Dismisses all of the Providers in PRRB Case No. 13-2285G with the exception of St. Mary's Medical Center of Evansville PN 15-0100 FYE 6/30/09, Jamaica Hospital Medical Center PN 33-0014 FYE 12/31/09, Caldwell Memorial Hospital PN 34-0041 FYE 9/30/09, and Weirton Medical Center PN 51-0023 FYE 6/30/09
- Dismisses all of the Providers in PRRB Case No. 14-0648G after moving Weirton Medical Center PN 51-0023 FYE 6/30/10 to PRRB Case No. 13-2285G, and removes the case from the Board's docket.

- Dismisses all of the Providers in PRRB Case No. 15-1671G after moving Thomas Memorial Hospital PN 51-0029 FYE 9/30/11 to PRRB Case No. 13-2285G, and removes the case from the Board's docket.
- Dismisses all of the Providers in PRRB Case No. 15-2538G after moving Thomas Memorial Hospital PN 51-0029 FYE 9/30/10 to PRRB Case No. 13-2285G, and removes the case from the Board's docket.
- Dismisses all of the Providers in PRRB Case No. 15-2641G after moving Thomas Memorial Hospital PN 51-0029 FYE 9/30/12 to PRRB Case No. 13-2285G, and removes the case from the Board's docket. The Board renames Case No. 13-2285G as Hall Render 2009-2012 Post 1498R DSH SSI Data Match Group.

The hearing for Case Nos. 13-1967, 13-1170G, 13-2285G, 13-1487GC, 13-3656GC, and 13-3843GC will be rescheduled. Revised Notices of Hearing will be issued under separate cover. 2018.

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

Board Members Participating:

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

FOR THE BOARD

Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

cc: Federal Specialized Services
Wilson C. Leong, Esq., CPA
PRRB Appeals
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cc: Mounir Kamal, Novitas Solutions, Inc. (Certified Mail)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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JUL 2 5 2018

CERTIFIED MAIL

James S. Battafarano
The Cleveland Clinic Health System
6801 Brecksville Road
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Independence, OH 44131

RE: Providers: **Cleveland Clinic 2013 Uncompensated Care Calculation CIRP Group and Cleveland Clinic 2014 Uncompensated Care Calculation CIRP Group**
Provider Nos.: 36-0180 and 36-0077
FYEs: December 31, 2013 and December 31, 2014
Case Nos: 16-1228GC and 17-1843GC

Dear Mr. Battafarano,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On March 14, 2016, and July 13, 2017, the Providers in the above-referenced group appeals filed group appeal requests with the Board from their September 16, 2015 and January 18, 2017 Notice of Program Reimbursements (NPRs). The Providers challenge the uncompensated care calculations used to determine their DSH payments.

The Providers contend the current Medicare Cost Report instructions related to Worksheet S-10 are ambiguous and could result in uncompensated care costs that are different from what is included in their cost reports. The Providers maintain there are potential errors associated with the published uncompensated care amounts reported on line 35 of Worksheet E Part A; however, CMS has not provided enough detail to be able to succinctly identify the error rate. The Providers assert they have included a protested amount as it relates to uncompensated care in order to preserve their future appeal rights pertaining to the cost of uncompensated care on Worksheet S-10.

The Providers maintain given the foregoing errors, the Medicare Contractor's uncompensated care calculations were inconsistent with the Congressional intent to reimburse hospitals for treatment of all indigent patients when determining DSH program eligibility and reimbursement. The Providers assert they are unable to determine whether their Medicare DSH payments are correct because they do not have access to all of the underlying information concerning the calculating of their payments. The Providers contend their appeal is not limited to challenging audit adjustments, the uncompensated care calculation issue is a challenge to the Secretary's underlying policy.[1]

[1] Providers' Group Appeal Requests Tab 2 at 1.

Board's Decision

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[2]

(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court in *Tampa General*[3] upheld the D.C. District Court's decision[4] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[5] The Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[6]

The Court also found *Tampa General's* argument that the statute creates no bar to a court reviewing the Secretary's ultimate decision as to the amount of a hospital's final DSH payment, but only the intermediate determination as to the estimate of a hospital's share of uncompensated care unpersuasive. The Court noted that this is a distinction without a difference. The Court stated the critical factor is not whether the statute barred from review the agency's ultimate determination or merely an intermediate step in reaching that decision. Rather, the Court found the dispositive issue is whether the challenged data are inextricably intertwined with an action that all agree is shielded from review, regardless of

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[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).

[3] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).

[4] 89 F. Supp. 3d 121 (D.D.C. 2015).

[5] 830 F.3d 515, 517.

[6] *Id.* at 519.

where that action lies in the agency's decision tree. The Court noted because the data is inextricably intertwined with the Secretary's estimate of uncompensated care, *Tampa General* cannot challenge the Secretary's choice of data in court.[7]

The Board finds that the same findings are applicable to the Providers' challenge to their 2013 and 2014 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FYs 2013 and 2014. In challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. In essence, the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. However, as the D.C. Circuit Court in *Tampa General* held, the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the uncompensated care DSH issue is the only issue in these appeals, the above-referenced group appeals are hereby closed and removed from the Board's docket.[8]

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD

Charlotte F. Benson, CPA
Board Member

cc: Wilson Leong, Federal Specialized Services
Judith E. Cummings, CGS Administrators

[7] *Id.* at 521.
[8] As the appeals are being dismissed in their entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for each group appeal to the decision.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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JUL 2 6 2018

CERTIFIED MAIL

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Novitas Solutions Inc.
Mounir Kamal
Director JH Provider Audit & Reimbursement
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RE: Baylor All Saints Medical Center
Provider No. 45-0137
FYE 09/30/2006
PRRB Case No. 16-1948

Dear Mr. Galinsky and Mr. Kamal,

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

Background

Baylor All Saints Medical Center is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in a Revised Notice of Program Reimbursement ("NPR") dated December 30, 2015. The Provider timely filed an appeal from the NPR on June 29, 2016. The Model Form A- Individual Appeal Request presented nine issues:

1. Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific);
2. Disproportionate Share Hospital/Supplemental Income (SSI);
3. Disproportionate Share Hospital Payment – SSI Fraction Medicare Managed Care Part C Days;
4. Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days);
5. Disproportionate Share Hospital Payment – Medicaid Fraction/ Medicare Managed Care Part C Days;
6. Disproportionate Share Hospital Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days);
7. Disproportionate Share Hospital Payment – Medicaid Eligible Days;

8. Disproportionate Share Hospital Payment – Medicare Managed Care Part C Days;
9. Disproportionate Share Hospital Payment – Dual Eligible Days.

On February 27, 2017 the Board received transfer requests from the Provider for the following issues:

- Supplemental Security Income Percentage, PRRB CN: 17-1179GC;
- SSI Fraction/Medicare Managed Care Part C Days. PRRB CN: 17-1180GC;
- Issues 5 & 8- Medicaid Fraction/ Medicare Managed Care Part C Days, PRRB CN:17-1180GC;
- SSI Fraction/Dual Eligible Days, PRRB CN: 17-1182GC;
- Issues 6 & 9: Medicaid Fraction/ Dual Eligible Days Group, PRRB CN: 17-1183GC.

Two issues remain pending: the SSI Provider Specific and Medicaid Eligible Days. The Medicaid Contractor has challenged jurisdiction over Issue 1 and Issues 5 through 9.

Medicare Contractor Contentions:

The Medicare Contractor has challenged jurisdiction over 6 issues: SSI Provider Specific; Medicaid Fraction/Medicare Managed Care Part C Days; Medicaid Fraction/Dual Eligible Days; Medicaid Eligible Days; Medicare Managed Care Part C Days; and Dual Eligible Days.

Issue 1 – SSI Provider Specific

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue and it is barred under Board rules for a Provider to appeal a duplicate issue. The Medicare Contractor also argues that the Board does not have jurisdiction over the SSI realignment subsidiary appeal because the appeal is premature. The Provider has not requested a realignment of its SSI ratio, therefore it has not exhausted all of its administrative remedies prior to requesting a PRRB appeal.

Issues 5-7 – Medicaid Fraction Issues

The Medicare Contractor argues that the Board does not have jurisdiction over Issues 5-7 because it did not render a final determination with respect to those issues. The Provider cites to adjustments 5, 6, 8, and self-disallowance as the sources of dissatisfaction. Adjustments 5, 6, and 8 were adjustments to the SSI ratio. The Medicare Contractor explains that the days associated with Issues 5, 6, and 7 (Part C Days and Dual Eligible Days in the Medicaid fraction and Medicaid eligible days), were not claimed by the Provider, and were not protested by the Provider, therefore the Medicare Contractor could not have rendered a final determination over the issues, therefore the Board does not have jurisdiction over the issues.

Issue 8 – Medicare Managed Care Part C Days

The Medicare Contractor contends that Issue 8, Medicare Managed Care Part C Days, is duplicative of Issue 3 and Issue 5: SSI Fraction/Part C Days and Medicaid Fraction/Part C Days, and should be dismissed as duplicative.

Issue 9 – Dual Eligible Days

The Medicare Contractor contends that Issue 9, Dual Eligible Days, is duplicative of Issue 4 and Issue 6, SSI Fraction/Dual Eligible Days and Medicaid Fraction/Dual Eligible Days, and should be dismissed as duplicative.

Board's Decision

Disproportionate Share Hospital (DSH) Payment/Supplemental Security Income (SSI) Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over Issue No. 1, the SSI Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue and should be dismissed by the Board.[1] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation."[2] The Provider's legal basis for Issue No. 1 also asserts that "the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[3] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ."[4]

However, the Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportionate Share Hospital/Supplemental Security Income percentage."[5] The Provider's legal basis for the Systemic Errors issue is that "the SSI percentages calculated by [CMS] and used by the Lead [Medicare Contractor] to settle their Cost Report [were] incorrectly computed . . . ."[6] Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred to a group appeal. Because the Systemic Errors issue is no longer in the individual appeal as it was transferred to a group appeal, the Board dismisses this aspect of Issue No. 1.

The second aspect of Issue No. 1—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the

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[1] Provider's Individual Appeal Request at Tab 3, Issue 1 and Issue 2.
[2] *Id.* at Tab 3, Issue 1.
[3] *Id.*
[4] *Id.*
[5] *Id.* at Tab 3, Issue 2.
[6] *Id.*

Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

Issues 5-7 – Medicaid Fraction Issues

The Board finds that it does not have jurisdiction over the following issues: Medicaid Fraction/Part C Days; Medicaid Fraction/Dual Eligible Days; and Medicaid Eligible days. The Provider appealed from a revised NPR that did not adjust the DSH Medicaid Fraction. There was no final determination rendered by the Medicare Contractor regarding Medicaid ratio issues. Therefore, the Provider has not preserved its right to claim dissatisfaction for the Medicaid ratio issues.

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2015) provides in relevant part:

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

42 C.F.R. § 405.1889 (2015) explains the effect of a cost report revision:

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

This Provider's revised NPR was issued in order to update its SSI percentage. There is nothing in the record to establish that the Provider's Medicaid fraction was adjusted, therefore the Board finds that it does not have jurisdiction over the Medicaid ratio issues for Part C Days and Dual Eligible Days issues or the Medicaid eligible days issue.

Issues 8 and 9 – Medicare Managed Care Part C Days and Dual Eligible Days

The Board finds that Issue No. 8, DSH – Medicare Managed Care Part C Days, is duplicative of both Issues Nos. 3 and 5 – the DSH – SSI Fraction/Medicare Managed Care Part C Days and DSH – Medicaid Fraction/Medicare Managed Care Part C Days issues, which are pending in a group appeal. The Board has determined, above, that it does not have jurisdiction over the Medicaid Fraction/Medicare Managed Care Part C Days issue because it was not adjusted in the Provider's revised NPR. Therefore, the Board denies jurisdiction over that issue and denies the Provider's request to transfer the issue to case no. 17-1180GC. The Board does, however, grant the transfer of Issues 3 and 8 to case no. 17-1180GC.

The Board finds that Issue No. 9, DSH – Dual Eligible Days, is duplicative of both Issues Nos. 4 and 6, the DSH – SSI Fraction/Dual Eligible Days and DSH – Medicaid Fraction/Dual Eligible Days issues, which are pending in group appeals. The Board has determined, above, that it does not have jurisdiction over the Medicaid Fraction/Dual Eligible Days issue because it was not adjusted in the Provider's revised NPR. Therefore, the Board denies jurisdiction over that issue and denies the Provider's request to transfer the issue to case no. 17-1183GC. The Board does, however, grant the transfer of Issues 4 and 9 to case no. 17-1182GC.

Conclusion

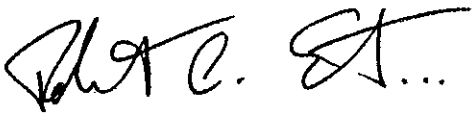
The Board finds that it does not have jurisdiction over the SSI Provider Specific issue; Medicaid Fraction/Medicare Managed Care Part C Days issue; Medicaid Fraction/Dual Eligible Days; and Medicaid Eligible days. The Board denies the transfer requests of the Medicaid Fraction/Medicare Managed Care Part C Days to case no. 17-1180GC and Medicaid Fraction/Dual Eligible Days issue to case no. 17-1183GC.

As no issues remain pending in the appeal, PRRB Case no. 16-1948 is hereby closed and removed from the Board's docket.

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

Board Members:
Gregory H. Ziegler, CPA, CPC-A
Charlotte F. Benson, CPA
Robert Evarts, Esq.

FOR THE BOARD



Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877
cc: Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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JUL 2 6 2018

Stephanie A. Webster, Esq.
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1333 New Hampshire Avenue, NW
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RE: **Expedited Judicial Review Determination**

15-1095GC	Methodist Health System 2010 DSH Medicare Fraction Medicare Advantage Days CIRP
15-1098GC	Methodist Health System 2010 DSH Medicaid Fraction Medicare Advantage Days CIRP
18-1267G	Akin Gump 2008 DSH Medicare Advantage Days Group 3
18-1284G	Akin Gump 2006 DSH Medicare Advantage Days Group 3
18-1295G	Akin Gump 2009 DSH Medicare Advantage Days Group 2
18-1404G	Akin Gump 2010-2011 DSH Medicare Advantage Days Group
18-1342	Kingsbrook Jewish Medical Center

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' July 20, 2018 request for expedited judicial review (EJR) (received July 23, 2018) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> Whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI[1]] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH[2] adjustment.[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] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[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 . . . . (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:

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

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[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. § 412.106(c)(1).
[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] 42 C.F.R. § 412.106(b)(2)-(3).

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

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[13] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

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

With the creation of Medicare Part C in 1997,[16] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

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[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004. [17]

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

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

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[19] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A.* We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (emphasis added)

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[17] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[19] 69 Fed. Reg. at 49,099.

[20] *Id.*

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[22] vacated the FFY 2005 IPPS rule. However, the Secretary has not acquiesced to that decision. More recently in *Allina Health Services v.* Price (*Allina II*),[23] the Court found that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction was vacated by *Allina Health Services* above. The Court found that the Secretary was required to undertake notice and comment ruling-making and the 2012 regulation was invalid. Once again, the Secretary has not acquiesced to this decision.

Providers' Request for EJR

The Providers point out that prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be included in the Medicaid fraction of the DSH adjustment.[24] In the May 2003 proposed rule for Federal fiscal year 2004, the Secretary proposed "to clarify" her long held position that "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."[25] Further, the Secretary went on, "[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients' days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction."[26] The Secretary explained that "once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary's benefits are no longer administered under Part A."[27]

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and adopted a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.[28] The Secretary's actions were litigated in *Allina I* in which the Court concluded that the Secretary's final rule was not a logical outgrowth of the proposed rule and a vacatur was warranted.[29]

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[21] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[22] 746 F. 3d 1102 (D.C. Cir. 2014).
[23] 2017 WL 3137976 (D.C. Cir. July 25, 2017).
[24] Providers' EJR Request at 4 citing to Allina 746 F.3d at 1105.
[25] 68 Fed Reg. at 27,208.
[26] *Id.*
[27] *Id.*
[28] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[29] Providers' EJR Request at 5-6.

The Providers are seeking EJR over the appeal because the Board does not have the authority to adjudicate the continued application of the 2004 rule and its policy change to the applicable portion of the cost years at issue.[30] The Providers point out that the Board continues to be bound by the regulation on Part C days unless the Secretary acquiesces in the *Allina* court rulings, which he has not done.[31]

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006 through 2011.

For purposes of Board jurisdiction over a participant's appeals filed from a cost reporting period that ends on or before December 30, 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.*[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.

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[30] *Id. at 10,* citing 42 C.F.R. § 405.1867 ("in exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and the regulations thereunder.").
[31] *Id.*
[32] 108 S.Ct. 1255 (1988).
[33] *Bethesda at 1258-59.*
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016)

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 or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or properly protested the appealed issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $10,000 for the individual appeal and $50,000, as required for a group appeal[37] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in this case.

Board's Analysis Regarding the Appealed Issue

The one individual and six group appeals in this EJR request span fiscal years 2006 through 2011, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[36] *Banner* at 142.
[37] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Everts, Esq.

FOR THE BOARD:

Gregory H. Ziegler

Gregory H. Ziegler, CPA, CPC-A
Board Member

Enclosures: 42 U.S.C. § 1395oo(f)
Schedules of Providers

Certified Mail w/ Schedules
cc: Mounir Kamal, Novitas Solutions, Inc. (J-H)
Pam VanArsdale, National Government Services, Inc. (J-K)
Wilson Leong, Federal Specialized Services (w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Refer to: 14-0857GC

JUL 27 2018

CERTIFIED MAIL

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

RE: HRS FMOLHS 2010 DSH SSI Percentage Baystate Errors CIRP Group FYE 2010
PRRB Case No.: 14-0857GC

Dear Ms. Goron,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' July 18, 2018 Request for Expedited Judicial Review ("EJR") (received July 19, 2018). The decision of the Board is set forth below.

BACKGROUND:

Previous Jurisdictional Determination

On November 18, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the "HRS 2010 FMOLHS DSH/SSI Percentage CIRP Group". The Board established case number 14-0857GC. At the same time, the Board received two other group appeal requests for FMPLHS 2010 and established four separate group appeals, each covering one distinct legal issue as required by regulation, 14-0870GC HRS FMOLHS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days, 14-0868GC HRS FMOLHS 2010 DSH SSI Fraction Medicare Managed Care Part C Days, 14-0864GC HRS FMOLHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP, and 14-0860GC HRS FMOLHS 2010 SSI Fraction Dual Eligible Days CIRP.

On May 4, 2018 the Medicare Contractor filed a jurisdictional challenge with the Board to which the Providers responded on June 6, 2018. On July 5, 2018 the Board issued a jurisdictional determination in which it found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA. In that decision, the Board dismissed several other sub-issues that it found resided in the other group appeals.

Request for EJR

On July 19, 2018, the Board received a request for EJR in this case of the following issues:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007);
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation; and
c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

The Provider further requests, that if the Board denies jurisdiction over the three issues of which they requested EJR, the Board clarify to what issue they have the authority to overturn. Further, the Provider asks for consolidation of this case with 10-1325GC for hearing.

BOARD'S DECISION:

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

The Board hereby denies the Providers' request for EJR of the three issues in case number 14-0857GCGC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. The only issue pending in this group is the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board confirms that these issues are in the following group appeals:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); is pending **in Case # 14-0870GC HRS FMOLHS 2010 DSH Medicaid Fraction Medicare Managed Care Part C Days and 14-0868GC HRS FMOLHS 2010 DSH SSI Fraction Medicare Managed Care Part C Days (those cases were EJR'd and closed on 3/20/18 and 4/13/18 respectively),**
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days

entitled to benefits under Part A for purposes of the DSH calculation is pending in **Case# 14-0864GC HRS FMOLHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group** and

c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) is pending in **Case# 14-0860GC HRS FMOLHS 2010 SSI Fraction Dual Eligible Days CIRP.**

CONCLUSION:

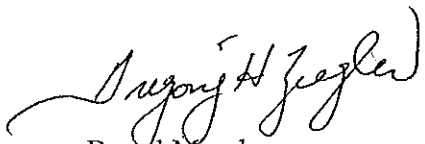
The Board hereby denies the Providers' request for EJR of the three issues in case number 14-0857GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. PRRB Case No. 14-0857GC remains open for the following issue: the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board also denies HRS's Request to consolidate this case with PRRB CN: 10-1325GC (Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group), which is a separate issue from this case. The PRRB CN: 10-1325GC is an appeal from SSI fraction published prior to the FY 2011 Final Rule (75 Fed. Reg. 50281) and therefore is a separate issue from appeals of SSI fractions published pursuant to the 2011 Final Rule (75 Fed. Reg. 50281).

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

For the Board:



Board Member

cc: Novitas Solutions, Inc.
Mounir Kamal Director JH, Provider Audit & Reimbursement
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Refer to: 13-3113GC

JUL 27 2018

CERTIFIED MAIL

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

RE: HRS FMOLHS 2007 DSH SSI Percentage Baystate Errors CIRP Group FYE 2007
PRRB Case No.: 13-3113GC

Dear Ms. Goron,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' July 18, 2018 Request for Expedited Judicial Review ("EJR") (received July 19, 2018). The decision of the Board is set forth below.

BACKGROUND:

Previous Jurisdictional Determination

On August 23, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the SSI *Baystate* errors issue for Franciscan Missionaries of Our Lady Health System ("FMOLHS") providers' 2007 fiscal year ends ("FYE") and established the current case # 13-3113GC. The Board also established the following group appeals: 13-3443GC HRS FMOLHS 2007 DSH Payment Dual Eligible Days CIRP Group, 15-0800GC HRS FMOLHS 2007 SSI Fraction Dual Eligible Days CIRP Group, 15-0799 HRS FMOLHS 2007 SSI Fraction Medicare Managed Care Part C Days CIRP Group and 13-3344GC HRS FMOLHS 2007 DSH Medicare Managed Care Part C Days CIRP Group.

The Medicare Contractor filed a jurisdictional challenge with the Board on April 3, 2018 to which the Providers responded on May 24, 2018. On July 5, 2018 the Board issued a jurisdictional determination in which it found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA. In that decision, the Board dismissed several other sub-issues that it found resided in the other group appeals.

Request for EJR

On July 19, 2018, the Board received a request for EJR in this case of the following issues:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007);
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation; and
c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

The Provider further requests, that if the Board denies jurisdiction over the three issues of which they requested EJR, the Board clarify to what issue they have the authority to overturn. Further, the Provider asks for consolidation of this case with 10-1325GC for hearing.

BOARD'S DECISION:

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

The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3113GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. The only issue pending in this group is the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board confirms that these issues are in the following group appeals:

a) The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); is pending in **PRRB Case# 15-0799 HRS FMOLHS 2007 SSI Fraction Medicare Managed Care Part C Days CIRP Group and 13-3344GC HRS FMOLHS 2007 DSH Medicare Managed Care Part C Days CIRP Group**
b) The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation is pending in **PRRB Case# 13-**

3443GC HRS FMOLHS 2007 DSH Payment Dual Eligible Days CIRP Group and

c) The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) is pending **in PRRB Case # 15-0800GC HRS FMOLHS 2007 SSI Fraction Dual Eligible Days CIRP Group.**

CONCLUSION:

The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3113GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. PRRB Case No. 13-3113GC remains open for the following issue: the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board also denies HRS's Request to consolidate this case with PRRB CN: 10-1325GC (Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group), which is a separate issue from this case. The PRRB CN: 10-1325GC is an appeal from SSI fraction published prior to the FY 2011 Final Rule (75 Fed. Reg. 50281) and therefore is a separate issue from the appeals of SSI fractions published pursuant to the 2011 Final Rule (75 Fed. Reg. 50281).

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

For the Board:

Gregory H. Ziegler

Board Member

cc: Novitas Solutions, Inc.
Mounir Kamal Director JH, Provider Audit & Reimbursement
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Refer to: 13-3120GC

CERTIFIED MAIL

JUL 27 2018

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

RE: HRS FMOLHS 2009 DSH SSI Percentage Baystate Errors CIRP Group FYE 2009
PRRB Case No.: 13-3120GC

Dear Ms. Goron,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' July 18, 2018 Request for Expedited Judicial Review ("EJR") (received July 19, 2018). The decision of the Board is set forth below.

BACKGROUND:

Previous Jurisdictional Determination

On August 23, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the "HRS 2009 FMOLHS SSI Percentage CIRP Group" and the Board established the current case# 13-3120G. On August 26th, 2013 the following appeals were also filed with the Board, 13-3303GC HRS FMOLHS 2009 DSH Medicare Managed Care Part C Days and 13-3304GC HRS FMOLHS 2009 DSH Payment Dual Eligible Days.

The Medicare Contractor filed a jurisdictional challenge with the Board on April 26, 2018 to which the Providers responded on June 6, 2018. On July 5, 2018 the Board issued a jurisdictional determination in which it found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA. In that decision, the Board dismissed several other sub-issues that it found resided in the other group appeals.

Request for EJR

On July 19, 2018, the Board received a request for EJR in this case of the following issues:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007);
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation; and
c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

The Provider further requests, that if the Board denies jurisdiction over the three issues of which they requested EJR, the Board clarify to what issue they have the authority to overturn. Further, the Provider asks for consolidation of this case with 10-1325GC for hearing.

BOARD'S DECISION:

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

The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3120GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. The only issue pending in this group is the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board confirms that these issues are in the following group appeals:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); is pending in **PRRB Case# 13-3303GC HRS FMOLHS 2009 DSH Medicare Managed Care Part C Days (13-3303GC was EJR'd on 3/2/2018).**
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation is pending **in 13-3304GC HRS FMOLHS 2009 DSH Payment Dual Eligible Days** and
c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH

calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) is pending **13-3304GC HRS FMOLHS 2009 DSH Payment Dual Eligible Days.**

CONCLUSION:

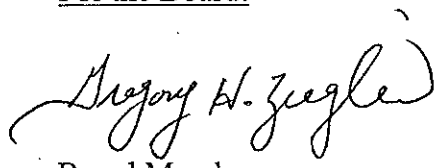
The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3120GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. PRRB Case No. 13-3120GC remains open for the following issue: the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board also denies HRS's Request to consolidate this case with PRRB CN: 10-1325GC (Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group), which is a separate issue from this case. The PRRB CN: 10-1325GC is an appeal from SSI fraction published prior to the FY 2011 Final Rule (75 Fed. Reg. 50281) and therefore is a separate issue from appeals of SSI fractions published pursuant to the 2011 Final Rule (75 Fed. Reg. 50281).

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

For the Board:



Board Member

cc: Novitas Solutions, Inc.
Mounir Kamal Director JH, Provider Audit & Reimbursement
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Refer to: 13-3117GC

JUL 2 7 2018

CERTIFIED MAIL

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

RE: HRS FMOLHS 2008 DSH SSI Percentage Baystate Errors CIRP Group FYE 2008
PRRB Case No.: 13-3117GC

Dear Ms. Goron,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' July 18, 2018 Request for Expedited Judicial Review ("EJR") (received July 19, 2018). The decision of the Board is set forth below.

BACKGROUND:

Previous Jurisdictional Determination

On August 23, 2013, the Board received the request to establish a Common Issue Related Party ("CIRP") group appeal for the SSI *Baystate* errors issue for Franciscan Missionaries of Our Lady Health System ("FMOLHS") providers' 2008 fiscal year ends ("FYE")and established the current case #13-3117GC. The Board also established the following group appeals: 13-3100GC HRS FMOLHS 2008 DSH Medicare Managed Care Part C Days and 13-3115GC HRS FMOLHS 2008 DSH Dual Eligible Days CIRP.

The Medicare Contractor filed a jurisdictional challenge with the Board on April 23, 2018 to which the Providers responded on May 24, 2018. On July 5, 2018 the Board issued a jurisdictional determination in which it found that the issue in this group appeal is limited to the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MEDPAR to the information provided by SSA. In that decision, the Board dismissed several other sub-issues that it found resided in the other group appeals.

Request for EJR

On July 19, 2018, the Board received a request for EJR in this case of the following issues:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007);
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation; and
c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010).

The Provider further requests, that if the Board denies jurisdiction over the three issues of which they requested EJR, the Board clarify to what issue they have the authority to overturn. Further, the Provider asks for consolidation of this case with 10-1325GC for hearing.

BOARD'S DECISION:

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

The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3117GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. The only issue pending in this group is the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board confirms that these issues are in the following group appeals:

a. The treatment of Part C days as days entitled to benefits under Part A for purposes of the DSH calculation, *see* 69 Fed. Reg. 48916, 49099 (Aug. 11, 2004); 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007); is pending in **PRRB Case# 13-3100GC HRS FMOLHS 2008 DSH Medicare Managed Care Part C Days (13-3100GC was EJR'd on 3/2/2018).**
b. The treatment of other days for which the beneficiary did not receive Part A payments, such as, but not limited to, days for which the beneficiary's Part A benefits were exhausted and days for which Medicare Part A was a secondary payor, as days entitled to benefits under Part A for purposes of the DSH calculation is pending in **PRRB Case #13-3115GC HRS FMOLHS 2008 DSH Dual Eligible Days CIRP** and

c. The treatment of days for individuals that have not received SSI payments as not entitled to SSI benefits for purposes of calculating the Medicare fraction of the DSH calculation; *see* 75 Fed. Reg. 50042, 50280 (Aug. 16, 2010) is pending in **PRRB Case #13-3115GC HRS FMOLHS 2008 DSH Dual Eligible Days CIRP.**

CONCLUSION:

The Board hereby denies the Providers' request for EJR of the three issues in case number 13-3117GC because the Board has already determined that these issues are not pending in this case, therefore the first requirement of 42 C.F.R. § 405.1842(f)(1) is not satisfied. PRRB Case No. 13-3117GC remains open for the following issue: the SSI Systemic Errors Issue as it relates to utilizing the best available data when matching the MedPAR to the information provided by SSA.

The Board also denies HRS's Request to consolidate this case with PRRB CN: 10-1325GC (Univ. of Washington 2007 SSI Covered vs. Total Days CIRP Group), which is a separate issue from this case. The PRRB CN: 10-1325GC is an appeal from SSI fraction published prior to the FY 2011 Final Rule (75 Fed. Reg. 50281) and therefore is a separate issue from appeals of SSI fractions published pursuant to the 2011 Final Rule (75 Fed. Reg. 50281).

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.

For the Board:

Gregory W Ziegler

Board Member

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CERTIFIED MAIL

JUL 2 7 2018

Morgan, Lewis & Bockius, LLP
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Partner
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RE: Jurisdictional Determination

CHSB 2013 DSH Uncompensated Care Payments CIRP Group, Case No. 16-2370GC
CarePoint 2013 Uncompensated Care CIRP Group, Case No. 16-2479GC
Geisinger 2014 Uncompensated Care CIRP Group, Case No. 17-0430GC
CarePoint 2014 Uncompensated Care CIRP Group, Case No. 17-1227GC
Rochester Regional Health 2014 Uncompensated Care CIRP Group, Case No. 18-0129GC
Sanford Health 2014 Uncompensated Care CIRP Group, Case No. 17-0545GC
CarePoint 2015 Uncompensated Care CIRP Group, Case No. 18-1365GC
Geisinger 2015 Uncompensated Care CIRP Group, Case No. 18-0027GC
Sanford 2015 Uncompensated Care – NPR Based CIRP Group, Case No. 18-1152GC

Dear Mr. Shay,

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

Pertinent Facts:

The various Providers in the above-referenced Common Issue Related Party ("CIRP") group appeals all filed their appeal requests from Notices of Program Reimbursement ("NPR"). The Providers contend that the rules establishing the Disproportionate Share Hospital ("DSH") uncompensated care payment methodology applicable to the Providers' cost reporting periods are invalid and result in an understatement of the Providers' DSH uncompensated care payments.

The Providers argue that CMS' understated determination of the DSH uncompensated care payment amount, the choice of data used to determine that amount, CMS' calculations, and the rules governing those determinations are *ultra vires*, arbitrary and capricious, not based on substantial evidence, and otherwise contrary to law.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). Based on

these provisions, judicial and administrative review is not available under 42 U.S.C. §§ 1395ff and 1395oo for:

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[1]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[2] upheld the D.C. District Court's decision[3] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[4] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[5]

The Board finds that the same findings are applicable to the Providers' challenge to their 2013, 2014, and 2015 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FYs 2013, 2014, and 2015. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred

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[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).

[3] 89 F. Supp. 3d 121 (D.D.C. 2015).

[4] 830 F.3d 515, 517.

[5] *Id.* at 519.

by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the above-referenced group appeals and removes them from its docket.

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

Board Members
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Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD

Gregory H. Ziegler

Board Member

Enclosures: 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877

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JUL 30 2018

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RE: **Expedited Judicial Review Determination**

16-1334GC	Continuum Health Partners 2005-2006 HMO Part C Days - Medicaid Fraction CIRP Group
16-1335GC	Continuum Health Partners 2005-2006 HMO Part C Days - Medicare Fraction CIRP
16-2457GC	Continuum Health Partners 2007-2008 HMO Part C Days Medicaid Fraction CIRP Group
16-2458GC	Continuum Health Partners 2007-2008 HMO Part C Days Medicare Fraction CIRP Group

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's request for expedited judicial review (EJR) received July 26, 2018, for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

> Whether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare Fraction and added to the Medicaid Fraction consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

prospective payment system ("PPS").[2] Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[9]
The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

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

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[10]

Medicare Advantage Program

The Medicare program permits its beneficiaries to receive services from managed care entities. The managed care statute implementing payments to health maintenance organizations ("HMOs") and competitive medical plans ("CMPs") is found at 42 U.S.C. § 1395mm. The statute at 42 U.S.C. § 1395mm(a)(5) provides for "payment to the eligible organization under this section for individuals enrolled under this section with the organization and entitled to benefits under part A of this subchapter and enrolled under part B of this subchapter . . ." Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[11] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[12]

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[10] 42 C.F.R. § 412.106(b)(4).
[11] of Health and Human Services.
[12] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[13]

With the creation of Medicare Part C in 1997,[14] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[15]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . (emphasis added)[16]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[17] In response to a comment regarding this change, the Secretary explained that:

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

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[13] *Id.*

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

[15] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

[17] 69 Fed. Reg. at 49,099.

> the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[18] (emphasis added)

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) 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 final rule was issued.[19] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[20] vacated the FFY 2005 IPPS rule. The Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2017), the Board is required to grant an EJR request if it determines that (i) the Board has jurisdiction to

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[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).

conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

Jurisdictional Determination

The participants in this EJR request have filed appeals involving fiscal years 2005 through 2008.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[21] 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.[22]

On August 21, 2008, new regulations governing the Board were effective.[23] 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).*[24] 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.[25]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on or after December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item

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[21] 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.).
[22] *Bethesda at 1258-59.*
[23] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[24] 201 F. Supp. 3d 131 (D.D.C. 2016)
[25] *Banner* at 142.

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 participants involved with the instant EJR request have had Part C days excluded from the Medicaid fraction, had a specific adjustment to the SSI fraction, or self-disallowed the issue such that the Board has jurisdiction to hear their respective appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[26] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2005 through 2008 cost reporting periods, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

[26] *See* 42 C.F.R. § 405.1837.

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' 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 there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

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

FOR THE BOARD:

Gregory H Ziegler

Board Member

Enclosures: 42 U.S.C. § 1395oo(f), Schedules of Providers

cc: Pam VanArsdale, NGS (Certified Mail w/ Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (w/Schedules of Providers)

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RE: Case Nos.: 15-1199GC, 15-1200GC, 15-1201GC, 16-0750GC, 16-0751GC, 16-0768G, 16-0769GC, 17-1042GC, 17-1152GC, 17-1153GC, 18-0447GC, 18-0448GC, 18-0528GC
Providers: Various King & Spalding, LLP FFYs 2015, 2016, 2017, and 2018 DSH Uncompensated Care Group Appeals
Provider Nos.: Various
FYEs: 9/30/2015, 9/30/2016, 9/30/2017 and 9/30/2018

Dear Mr. Polston;

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On January 28, 2015, January 19th, 27th, 2016, February 14th, 17th, 2017, and January 4th, 19th, 2018, the Providers in the above-referenced group appeals filed group appeal requests with the Board from the August 22, 2014, August 17, 2015, August 22, 2016, and August 14, 2017 Final Rules setting forth the federal fiscal years (FFY) 2015, 2016, 2017, and 2018 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge CMS' calculation of the pool of uncompensated care payments available for distribution to DSH hospitals as finalized in the 2015, 2016, 2017, and 2018 IPPS rulemakings.[2]

The Providers contend CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the uncompensated care payments available for distribution to DSH eligible hospitals in its calculation of Factors 1 and 2 (the distribution pool). The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. Thus, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply.

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014), 80 Fed. Reg. 49,326, 49515-30 (Aug. 17, 2015), 81 Fed. Reg. 56762, 56946-73 (Aug. 22, 2016), and 82 Fed. Reg. 37990, 38192-200 (August 14, 2017).
[2] Jurisdictional Challenges were filed in the above-referenced group appeals. The Board's decision responds to these jurisdictional documents as well.

The Providers argue CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. The Providers contend CMS failed to provide sufficient information regarding its calculation of the proposed distribution pool to allow for the presentation of relevant comments by the Providers. The Providers assert CMS specifically acknowledged in the final rule that the distribution pool was lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services. The Providers argue this assumption is not supported by any evidence and was not disclosed until the final rulemaking, thereby entirely depriving the Providers the right to challenge the assumption or to offer countervailing arguments.[3]

The Providers maintain while the preclusion of review provision may protect the substance of CMS' determinations from review, it does not give CMS *carte blanche* to disregard the procedural safe-guards established for how CMS arrives at those determinations. The Providers contend the preclusion of review provision is not an invitation for CMS to regulate by foregoing notice and comment rulemaking.

The Providers assert CMS also acted beyond its authority in failing to adhere to the binding decision of the District of Columbia Circuit Court in *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014). The Providers contend the 2011 baseline number employed by CMS in calculating the distribution pool is significantly understated because in contravention of the D.C. Circuit's holding in *Allina*, it continues to systematically treat patient days paid under Part C as days entitled to benefits under Part A, which results in a significant reduction to the distribution pool. The Providers argue since CMS is using 2011 as the baseline period, and in 2011 there was no valid agency policy of treating patient days paid under Part C as days entitled to benefits under Part A, CMS was obligated to correct that baseline number to conform to the court's binding determination in *Allina*. The Providers contend the 2011 baseline was calculated in reliance on CMS' policy of treating patient days paid under Part C as days entitled to benefits under Part A; *Allina* has specifically held that that policy is null and void. As such, CMS has acted beyond its authority by violating a binding determination of the judicial branch.[4]

Board's Decision

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]

(B) Any period selected by the Secretary for such purposes.

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[3] Providers' Group Appeal Requests at 1-2.

[4] *Id.* at 3.

[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).

Further, the D.C. Circuit Court in *Tampa General*[6] upheld the D.C. District Court's decision[7] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for FFY 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in April 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of *Tampa General's* claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The Circuit Court also rejected *Tampa General's* argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The Circuit Court also found *Tampa General's* argument that because the statute directs the Secretary to base her estimates on appropriate data, any estimate based on inappropriate data is *ultra vires* unpersuasive. The Court noted to challenge agency action on the ground that it is *ultra vires, Tampa General* must show a patent violation of agency authority. The Court found the Secretary's choice of data is not obviously beyond the terms of the statute; and by asking the Court to review the appropriateness of the data the Secretary used to calculate *Tampa General's* DSH payment, the Provider is asking the Court to engage in the kind of case-by-case review of the reasonableness or procedural propriety of the Secretary's individual applications that Congress intended to bar.[10]

The Board finds that the same findings are applicable to the Providers' challenge to their 2015, 2016, 2017 and 2018 uncompensated care payments. Similar to *Tampa General*, the Providers here are challenging CMS' calculation of the size of the pool of uncompensated care payments available for distribution. The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. In challenging CMS' calculation of the uncompensated care distribution pool, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their payment amounts. Although the Providers here are challenging additional parts of the uncompensated care calculation (Part C days) than in *Tampa General*, they are still challenging the underlying data.

The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by

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[6] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*, 830 F.3d 515, 517-18 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 522.

statute and regulation. As the uncompensated care DSH issue is the only issue in these appeals, the above-referenced group appeals are hereby closed and removed from the Board's docket.[11]

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Robert Evarts, Esq.

FOR THE BOARD

Charlotte F. Benson, CPA
Board Member

cc: Wilson Leong, Federal Specialized Services
Pam VanArsdale, National Government Services, Inc.
Byron Lamprecht, WPS Government Health Administrators
Laurie Polson, Palmetto GBA c/o National Government Services
Cecile Huggins, Palmetto GBA
Mounir Kamal, Novitas Solutions, Inc.
Bruce Snyder, Novitas Solutions, Inc.

[11] As the appeals are being dismissed in their entirety on subject matter jurisdiction, the Board is not attaching the Schedule of Providers for each group appeal to the decision.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

JUL 30 2018

CERTIFIED MAIL

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Ave., NW
Suite 200
Washington, DC 20006-4706

RE: Case Nos.: 15-1132GC, 15-1134GC, 15-1202GC, 15-1216G, 15-1217GC, 16-0753GC, 16-0767GC, 16-0808GC, 17-1041GC, 17-1091GC, 17-1150GC, 17-1151G, 18-0449GC, 18-0622G
Providers: Various King & Spalding, LLP FFYs 2015, 2016, 2017, and 2018 DSH Uncompensated Care Group Appeals
Provider Nos.: Various
FYEs: 9/30/2015, 9/30/2016, 9/30/2017 and 9/30/2018

Dear Mr. Polston,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced group appeals. The Board finds that it does not have jurisdiction over the uncompensated care disproportionate share hospital (DSH) payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

Background

On January 28, 2015, January 19th, 22nd, 27th, 2016, February 14th, 17th, 21st, 2017, and January 10th, 26th, 2018, the Providers in the above-referenced group appeals filed group appeal requests with the Board from the August 22, 2014, August 17, 2015, August 22, 2016, and August 14, 2017 Final Rules setting forth the federal fiscal years (FFY) 2015, 2016, 2017, and 2018 Inpatient Prospective Payment System (IPPS) rates.[1] The Providers challenge CMS' calculation of the pool of uncompensated care payments available for distribution to DSH hospitals as finalized in the 2015, 2016, 2017, and 2018 IPPS rulemakings.

The Providers contend CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the uncompensated care payments available for distribution to DSH eligible hospitals in its calculation of Factors 1 and 2 (the distribution pool). The Providers maintain CMS' determination of the distribution pool was beyond its authority, *ultra vires*. Thus, the preclusion of review provision found in the Social Security Act § 1886(r)(3) does not apply.

The Providers argue CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. The Providers contend CMS failed to provide

[1] 79 Fed. Reg. 49854, 50,008-22 (Aug. 22, 2014), 80 Fed. Reg. 49,326, 49515-30 (Aug. 17, 2015), 81 Fed. Reg. 56762, 56946-73 (Aug. 22, 2016), and 82 Fed. Reg. 37990, 38192-200 (August 14, 2017).

sufficient information regarding its calculation of the proposed distribution pool to allow for the presentation of relevant comments by the Providers. The Providers assert CMS specifically acknowledged in the final rule that the distribution pool was lower than the commenters may have expected due to the assumption that the expansion population is healthier than the rest of the Medicaid population and will utilize fewer hospital services. The Providers argue this assumption is not supported by any evidence and was not disclosed until the final rulemaking, thereby entirely depriving the Providers the right to challenge the assumption or to offer countervailing arguments.[2]

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Board's Decision

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

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[2] Providers' Group Appeal Requests at 1-2.

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[4] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634 (August 19, 2013).

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The Board finds that it does not have jurisdiction over the uncompensated care DSH issue in the above referenced group appeals because judicial and administrative review of the calculation is barred by

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[6] 89 F. Supp. 3d 121 (D.D.C. 2015).
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[8] *Id.* at 519.
[9] *Id.* at 522.

statute and regulation. As the uncompensated care DSH issue is the only issue in these appeals, the above-referenced group appeals are hereby closed and removed from the Board's docket.[10]

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