DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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OCT 02 2018

RE: Expedited Judicial Review Determination

13-3036	Methodist Healthcare – Memphis	12/31/2006
13-3038	Methodist Healthcare – Memphis	12/31/2010
13-3039	Methodist Healthcare – Memphis	12/31/2008
13-3040	Methodist Healthcare – Memphis	12/31/2007
13-3041	Methodist Healthcare – Memphis	12/31/2009

Dear Ms. Philp:

The Provider Reimbursement Review Board (Board) has reviewed the Provider's September 20, 2018 request for expedited judicial review (EJR) (received September 21, 2018). The Board's determination is set forth below.

The issue in these appeals is:

> [W]hether inpatient days attributable to patients enrolled in Medicare Part C plans should be included in the Medicaid percentage or the Medicare/Supplemental Security Income percentage of the disproportionate share hospital ("DSH") calculation.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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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.*
[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.

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)

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]

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[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).
[10] 42 C.F.R. § 412.106(b)(4).

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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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[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 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.

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 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.

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[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.
[18] *Id.*

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* (*Allina*),[20] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.

Provider's Request for EJR

The Provider contends that the Secretary's policy, announced in the FY 2005 IPPS rule, to include Part C days in the Medicare/SSI fraction and to exclude such days for dual-eligibles from the Medicaid fraction, is procedurally and substantively invalid under the Medicare statute and the Administrative Procedure Act. Further, the Provider asserts the application of this policy to its cost reporting periods at issue here also contravenes the D.C. Circuit's decision to vacate the rule in *Allina*.

The Provider believes that the Secretary's policy violates the Medicare statute and is invalid. The Provider points out that patients enrolled in a Medicare Part C plan receive their benefits under Part C of the Medicare statute, not Part A.[21] Accordingly, these patients are not "entitled to benefits under Part A" for the purposes of calculating DSH reimbursement. The Provider asserts that any policy that includes Part C days in the Medicare/SSI fraction (and excludes Part C days attributable to Medicaid-eligible patients from the Medicaid fraction) is contrary to and an unreasonable interpretation of the Medicare statute. The Provider reasons that the days attributable to Medicaid-eligible patients enrolled in a Part C managed care plan should be included in the Medicaid percentage of the Medicare DSH calculation and excluded from the numerator and the denominator of the Medicare/SSI fraction.

Further, the Provider argues that, the FY 2005 IPPS rule purporting to change the DSH policy for Part C days was promulgated in violation of the Medicare statute and the APA, and is, therefore, invalid. The Secretary is alleged to have failed to have provided adequate notice to the public of the proposed regulation to give interested persons an opportunity to comment.[22] The Provider believes that the Secretary flouted the requirements when the 2005 rule announced his interpretation to include Part C days in the Medicare/SSI fraction and exclude the days from the Medicaid fraction. The Provider contends that the Secretary did not draft the 2003 proposed IPPS rule in a manner that "interested parties 'should have anticipated' that the change was possible" and should have filed comments during the notice a comment-and-comment period.

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[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).
[21] *See* 42 U.S.C. § 1395w-21.
[22] *See* 5 U.S.C. § 553(b)-(c); 42 U.S.C. § 1395hh(b)(1) and 42 U.S.C. § 1395hh(a)(2).

As a result, the FY 2005 rule, which was codificd in 2007 without notice and comment rule-making procedures.

The Provider believes the Board must grant the request for EJR because it has jurisdiction over the appeals, but lacks the authority to decide the validity of 42 C.F.R. § 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

Decision of the Board

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

Jurisdictional Determination

The Provider in this EJR request has filed appeals involving fiscal years 2006 through 2010.

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

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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. 30,190, 30,240 (May 23, 2008).
[26] 201 F. Supp. 3d 131 (D.D.C. 2016).

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[28] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participant involved with the instant EJR request which appealed original Notices of Program Reimbursement are governed by the provisions of CMS Ruling 1727-R. The Provider's case (case number 13-3036) which was appealed from a revised NPR had an adjustment to the SSI percentage, as required by 42 C.F.R. § 405.1889. In addition, the participant's documentation shows that in each case that the estimated amount in controversy exceeds $10,000, as required for an individual 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 appeals in this EJR request involve fiscal years 2006 through 2010 thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed,* No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

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[27] *Banner* at 142.
[28] See 42 C.F.R. § 405.1889(b)(1) (2008).
[29] *See* 42 C.F.R. § 405.1835.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

cc: Mounir Kamal, Novitas Solutions (Electronic Mail)
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OCT 02 2018

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RE: Jurisdictional Determination
California Pacific Medical Center - Davies Campus
Provider No.: 05-0008
FYEs: December 31, 2008
PRRB Case No.: 13-1265

Dear Mr. Jaeger and Ms. Frewert:

This case involves California Pacific Medical Center - Davies Campus' ("California Pacific" or "Provider") appeal of its Medicare reimbursement for the fiscal year ending ("FYE") on December 31, 2008. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed California Pacific's documentation in response to the Medicare Contractor's July 25, 2017 Jurisdictional Challenge. Following review of the documentation, the Board finds that it does not have jurisdiction to hear California Pacific's Capital Disproportionate Share Hospital ("DSH") reimbursement issue, dismisses this issue from the instant appeal and, as this issue was the only remaining issue, closes PRRB Case No. 13-1265.

Pertinent Facts

On March 25, 2013, the Board received California Pacific's request for a hearing ("RFH") regarding its October 5, 2012 Notice of Program Reimbursement ("NPR") for the cost reporting period ending on December 31, 2008. In its RFH, California Pacific lists six issues for appeal, but following California Pacific's requests to transfer most of the issues to group appeals, the instant case was left with only one issue—Issue 6, Capital DSH "Correction of Calculation Error."

On July 26, 2017, the Board received the Medicare Contractor's Jurisdictional Challenge (dated July 25, 2017) in which the Contractor questions the Board's jurisdiction to consider California Pacific's Capital DSH issue.[1] Within its Jurisdictional Challenge, the Contractor argues that

[1] The Medicare Contractor's Jurisdictional Challenge questions Board jurisdiction to hear a "sub-part" of two issues that were transferred to group appeals. The two issues are Issue 3, DSH SSI Part C Managed Care Days Inclusion in SSI Ratio, and Issue 4, DSH SSI Part A Managed Care Days Inclusion in SSI Ratio. RFH TAB 3 at 1. Within its Jurisdictional Challenge, the Medicare Contractor argues that the Board does not have jurisdiction to hear part of California Pacific's Issues 3 and 4, namely the portions of the issues pertaining to the low income patient ("LIP")

California Pacific did not certify, on its cost report, that it qualified for Capital DSH, thus its Capital DSH issue is a "calculation error" and not an appeal from the Medicare Contractor's final determination.[2]

California Pacific filed a response to the Medicare Contractor's Jurisdictional Challenge in its Final Position Paper.

Board's Analysis and Decision

Issue 6—Capital DSH Reimbursement

Within its RFH, California Pacific titles its Issue 6 as "Correction of Cost Report Error—Capital DSH Worksheet L."[3] When describing this issue, California Pacific states the following:

> This issue is not the result of a specific adjustment. This issue is derived from a cost report software mathematical flow through and calculation error.
>
> . . .
>
> [T]he SSI ratio did not automatically flow from Worksheet E, Part A, Line 4 to Worksheet L, Part I, Line5. This clerical error resulted with no capital DSH reimbursement thereby denying valid reimbursement.[4]

In its Jurisdictional Challenge, the Medicare Contractor argues that in order to qualify for Capital DSH reimbursement, a provider must certify, on the cost report, that "it qualifies to be reimbursed pursuant to 42 C.F.R. § 412.320, by responding to the question on Worksheet S-2, Line 36.01 with "Y" for Title XVIII[,]" but California Pacific responded with "N" indicating that it did not qualify for Capital DSH reimbursement."[5] The Medicare Contractor goes on to state that based upon the provider's response to the threshold question described prior, the Medicare Contractor did not make a determination regarding Capital DSH when it settled California Pacific's cost report. The Medicare Contractor also points out that California Pacific did not include any protested amounts on its as-filed cost report.

Applicable Regulatory Provisions and Board's Analysis

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adjustment for IRFs. Jurisdictional Challenge at 2. In its Final Position Paper, California Pacific states that it transferred its Issues 3 and 4 to common issue related party ("CIRP") group appeals, thus leaving only Issue 6 in the instant appeal. California Pacific's Final Position Paper at 2, 13-14, and 15-16. As such, the portion of the Medicare Contractor's Jurisdictional Challenge pertaining to the LIP "sub-issues" will be addressed within the respective CIRP group appeals.

[2] Medicare Contractor's July 25, 2017 Jurisdictional Challenge at 3-4.

[3] RFH TAB 3 at 1.

[4] RFH TAB 3 at 8-9.

[5] Jurisdictional Challenge at 2 (emphasis omitted).

Applicable Regulatory Provisions and Board's Analysis

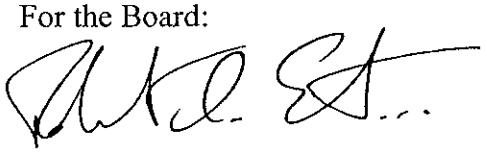
Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more,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

The Medicare Contractor claims that California Pacific's "N" response to the Capital DSH question on the cost report resulted in its lack of Medicare reimbursement for this item when the Contractor settled the cost report. In its Final Position Paper, California Pacific describes its issue as a "clerical error"[6] but does not explain how, under the pertinent regulations, the Board has jurisdiction to review such a clerical error within the context of a Board hearing. Therefore, the Board finds that California Pacific has not preserved its right to claim dissatisfaction with the amount of Capital DSH Medicare payment as required under 42 C.F.R. § 405.1835(a)(1) thus it does not have jurisdiction to hear California Pacific's appeal of this issue and dismisses it from the instant case. As California Pacific states that this is the only issue remaining in the appeal, the Board hereby closes the case.

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

Board Members Participating:
Charlotte F. Benson, CPA
Gregory Ziegler, CPA, CPC-A
Rob 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: Jerrod Olszewski, Federal Specialized Services
Wilson Leong, Federal Specialized Services

[6] California Pacific's Final Position Paper at 19.

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RE: Jurisdictional Determination
Ardent Health Services 2007 & 2008 Part C Days LIP Adjustment CIRP Group
Ardent HS 2009-2011 Medicare Part C Days LIP Adj. CIRP Group
Provider Nos.: 32-3028, 37-T001
FYEs: 6/30/2007, 8/31/2007, 8/31/2008, 8/31/2009, 8/31/2010, 8/31/2011
PRRB Case Nos.: 13-2029GC, 14-1143GC

Dear Mr. Hettich and Mr. Kamal:

This case involves Ardent Health Services' ("Ardent" or "Provider") appeal of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007 through 2011. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On April 2, 2013, the Board received Ardent's request for a hearing ("RFH") regarding its October 5, 2012, and October 10, 2012, Notices of Program Reimbursement ("NPR") for the cost reporting periods ending on 6/30/2007, 8/31/2007, and 8/31/2008. In its RFH, Ardent lists a single issue under appeal — a challenge to the inclusion of Part C days in the SSI percentage and the exclusion of such days from the Medicaid percentage in the determination of their LIP adjustment payments.

On November 26, 2013, the Board received Ardent's RFH regarding its June 5, 2013, September 6, 2013, and October 2, 2013, NPR for the cost reporting periods ending on 8/31/2009, 8/31/2010, and 8/31/2011. In its RFH, Ardent lists the same single issue under appeal — a

challenge to the inclusion of Part C days in the SSI percentage and the exclusion of such days from the Medicaid percentage in the determination of their LIP adjustment payments.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Incorrect Treatment of Part C Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory

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

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeal, the Provider seeks Board review of one of the components utilized by the Medicare Contractor to determine Mount Sinai's LIP adjustment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment.

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

Board Members Participating:

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

For the Board:

10/10/2018

X Charlotte Benson

Charlotte F. Benson
Board Member
Signed by: Charlotte Benson -A

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

[3] *Mercy*, 891 F.3d at 1068.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Geoff Pike, Appeals Lead
First Coast Service Options, Inc.
Provider Audit and Reimbursement Dept.
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Jacksonville, FL 32202

RE: Jurisdictional Determination
K&S 2012 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
K&S 2013 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
K&S 2014 Low Income Pool Sec. 1115 Rehab DSH Waiver Days Group
Provider Nos.: 10-0002, 10-T002, 10-0018, 10-T018, 10-0022, 10-T022, 10-0038, 10-T038, 10-0087, 10-T087
FYEs: 4/30/2012, 9/30/2012, 4/30/2013, 9/30/2013, 4/30/2014, 9/30/2014
PRRB Case Nos.: 15-1139G, 15-3219G, 17-1206G

Dear Mr. Polston and Mr. Pike:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2012, 2013, and 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On January 16, 2015, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPRs") dated October 27, 2014, July 22, 2014, December 1, 2015, February 13, 2015, and August 26, 2015, all corresponding to FYEs ending in 2012. In its RFH, the Providers' list a single issue for appeal — the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On August 17, 2015, the Board received the group representative's RFH regarding NPRs dated April 13, 2015, July 28, 2015, and October 5, 2015, all corresponding to FYEs ending in 2013. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of

days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on March 3, 2017, the Board received the group representative's RFH regarding NPRs dated October 12, 2015, and February 13, 2017, all corresponding to FYEs ending in 2014. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of days associated with the Section 1115 Rehab Medicare Florida Low-Income Pool waiver from the numerator of the Medicaid fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for IRFs. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients

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

served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment.

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

Board Members Participating:

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

For the Board:

10/12/2018

X Charlotte Benson

Charlotte F. Benson
Board Member
Signed by: Charlotte Benson -A

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

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[3] *Mercy*, 891 F.3d at 1068.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Jurisdictional Determination
WakeMed 2011 LIP Medicare/Medicaid Fraction Part C Days CIRP Group
WakeMed 2011 LIP SSI Post 1498R Data Match CIRP Group
WakeMed 2012 LIP Medicare/Medicaid Fraction Part C Days CIRP Group
WakeMed 2012 LIP SSI Post 1498R Data Match CIRP Group
Provider Nos.: 34-T069
FYEs: 9/30/2011, 9/30/2012
PRRB Case Nos.: 18-1129GC, 18-1120GC, 18-1127GC, 18-1126GC

Dear Ms. Griffin and Ms. Polson:

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

Pertinent Facts

On March 15, 2018, the Board received WakeMed's four (4) separate requests for hearings ("RFH") regarding Notices of Program Reimbursement ("NPR") dated September 18, 2017, and September 19, 2017, for the cost reporting periods ending on 9/30/2011 and 9/30/2012. In its RFH, WakeMed lists a single issue for appeal — a challenge to the calculation of the Medicare percentage and/or of low income patients for the low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

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

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Provider seeks Board review of both of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeals of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment.

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

Board Members Participating:

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

For the Board:

10/15/2018

X Charlotte Benson

Charlotte F. Benson
Board Member
Signed by: Charlotte Benson -A

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 18 2018

Thomas P. Knight
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RE: **Expedited Judicial Review Determination**

Toyon 2006-2013 DSH Part C Days Group Appeals EJR-See attached list

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 20, 2018 request for expedited judicial review (EJR) (received September 21, 2018). The Board's determination is set forth below.[1]

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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] The Group Representative withdrew the request for EJR for case numbers 14-3782GC, 16-1179G and 16-1182G through correspondence dated October 1 and 3, 2018.
[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)

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]

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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).
[11] 42 C.F.R. § 412.106(b)(4).

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

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)

Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[17] 69 Fed. Reg. 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,*[22] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

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

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.

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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] 69 Fed. Reg. at 49,099.
[24] *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 participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006-2013.

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

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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. 30,190, 30,240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016).
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For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[30] The Board notes that all participants revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request which appeal original Notices of Program Reimbursement are governed by the provisions of CMS Ruling 1727-R. The Providers which appealed from revised NPRs had adjustments to the SSI percentage, as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[31] 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 fiscal years 2006-2013 thus the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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[30] See 42 C.F.R. § 405.1889(b)(1) (2008).
[31] *See* 42 C.F.R. § 405.1837.

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 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, the Board hereby closes the cases.

Board Members Participating:

Clayton J. Nix, Esq.
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FOR THE BOARD:

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Chair

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian (Electronic Mail w/ Schedules of Providers)
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Danene Hartley, NGS (Electronic Mail w/ Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/ Schedules of Providers)

10-0253GC	NorthBay 2006 Inclusion of Dual Eligible Part C Days CIRP Group
11-0038GC	Providence 2006 DSH Dual Eligible Part C Days CIRP Group
13-0435GC	St. Joseph HS 2007 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
13-0568GC	John Muir Post 1498-R 2006 Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
13-0575GC	NorthBay Post 1498-R 2006 Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-0023GC	Essentia 2007 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-0765GC	DOC 2007 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-1421GC	Essentia 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-2803GC	DOC 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-2807GC	DOC 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3483GC	St. Joseph HS 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3778GC	Essentia 2010 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3993GC	NorthBay 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3999GC	NorthBay 2007 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-4002GC	NorthBay 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
15-0879GC	Essentia 2011 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 10/17/12 CIRP Group
15-1584GC	St. Joseph HS 2012 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 6/27/13 CIRP Group
15-2121G	Toyon 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group #2
15-2764GC	Palomar Pomerado 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group

16-0019G	Toyon 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group #2
16-0047GC	John Muir 2011 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 6/27/13 CIRP Group
16-0502GC	CHW Post-10/1/2004 DSH Part C Days CIRP Group
16-0877GC	Hawaii Pacific 2005-2007 DSH Part C Days CIRP Group
16-0917GC	NorthBay Post 10/1/2004 & 2005 Part C Days CIRP Group
16-1328G	Toyon 2012 Exclusion of Dual Eligible Part C Days - Medicaid Ratio Group
16-2087GC	John Muir 2005 DSH Part C Days CIRP Group
16-2580G	Toyon 2011 Exclusion of Dual Eligible Part C Days - Medicaid Ratio Group
16-2582G	Toyon 2011 Inclusion of Medicare Part C Days in the SSI Ratio Group
17-0293GC	Verity 2013 Exclusion of Dual Eligible Part C Days - Medicaid Ratio CIRP Group
17-0294GC	Verity 2013 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group
17-1395G	Toyon 2007 Exclusion of Dual Eligible Part C Days - Medicaid Ratio Group
17-1941GC	Verity 2006 Exclusion of Dual Eligible Part C Days - Medicaid Ratio CIRP Group
17-1943GC	Verity 2006 Inclusion of Medicare Part C Days in the SSI Ratio CIRP Group
18-0917GC	John Muir 2009 Exclusion of Dual Eligible Part C Days - Medicaid Ratio CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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OCT 18 2018

Thomas P. Knight
Toyon Associates, Inc.
1800 Sutter Street
Suite 600
Concord, CA 94520-2546

RE: **Expedited Judicial Review Determination**

Toyon 2005-2012 DSH Part C Days Group Appeals EJR-See attached list

Dear Mr. Knight:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 20, 2018 request for expedited judicial review (EJR) (received September 21, 2018). The Board's determination is set forth below.[1]

The issue in these appeals is:

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

Statutory and Regulatory Background: Medicare DSH Payment

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

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] The Group Representative withdrew the request for EJR for case numbers 14-3782GC, 16-1179G and 16-1182G through correspondence dated October 1 and 3, 2018.
[2] Providers' EJR Request at 4.
[3] *See* 42 U.S.C. § 1395ww(d)(1)-(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)

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]

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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).
[11] 42 C.F.R. § 412.106(b)(4).

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 care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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[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 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.

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 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.

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[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.
[19] *Id.*

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,*[21] vacated the FFY 2005 IPPS rule. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.

Providers' Request for EJR

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

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.[22] 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."[23] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

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[20] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] 69 Fed. Reg. at 49,099.
[23] *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 participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2005-2012.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[24] 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.[25]

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[27] 201 F. Supp. 3d 131 (D.D.C. 2016).
[28] *Banner* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[29] The Board notes that all participants revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that participants involved with the instant EJR request which appeal original Notices of Program Reimbursement are governed by the provisions of CMS Ruling 1727-R. The Providers which appealed from revised NPRs had adjustments to the SSI percentage, as required by 42 C.F.R. § 405.1889. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[30] 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 fiscal years 2005-2012 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.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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[29] See 42 C.F.R. § 405.1889(b)(1) (2008).
[30] *See* 42 C.F.R. § 405.1837.

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 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, the Board hereby closes the cases.

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Robert A. Evarts, Esq.
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FOR THE BOARD:

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Wilson Leong, FSS (Electronic Mail w/ Schedules of Providers)

Toyon Associates, Inc.

EJR Request - DSH Part C Days Group Appeals

Toyon Part C Appeals - EJR Granted II

10-0026G	Toyon 2007 DSH Dual Eligible Part C Days Group
)027GC	St. Joseph HS 2007 DSH Dual Eligible Part C Days CIRP Group
/037G	Toyon 2005 DSH Dual Eligible Part C Days Group
13-0483G	Toyon 2007 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group
13-2309G	Toyon 2006 DSH Dual Eligible Part C Days/SSI Group
13-3694G	Toyon 2008 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group
14-0799G	Toyon 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group
14-2800GC	Dignity Health 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3111GC	Essentia 2009 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
14-3140G	Toyon 2010 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 Group
15-0519GC	St. Joseph HS 2011 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 10/17/12 CIRP Group
15-2614G	Toyon 2011 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 10/17/12 Group
15-2618G	Toyon 2012 Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 6/27/13 Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Elizabeth Elias
Hall, Render, Killian, Heath & Lyman, P.C.
500 N. Meridian St., Suite 400
Indianapolis, IN 46204

Mounir Kamal
Novitas Solutions, Inc.
Union Trust Building
501 Grant Street, Suite 600
Pittsburgh, PA 15219

RE: Jurisdictional Determination
Good Shepard HS 2009 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Good Shepherd 2007 Rehab SSI Fraction Dual Eligible Days CIRP
Good Shepherd Health System 2010 LIP SSI Fraction Dual Eligible Days CIRP
Good Shepherd Health System 2013 LIP SSI Fraction Dual Eligible Days CIRP Group
Provider Nos.: 45-T032, 45-T037
FYEs: 9/30/2007, 9/30/2009, 9/30/2010, 9/30/2013
PRRB Case Nos.: 15-2849GC, 16-1955GC, 17-1445GC, and 17-0357GC

Dear Ms. Elias and Mr. Kamal:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007, 2009, 2010, and 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On January 8, 2014, the Board received the group representative's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") dated September 6, 2013, corresponding to FYE ending in 2009. In its RFH, the Providers' list a single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On June 16, 2016, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated August 3, 2012, and October 17, 2012, all corresponding to FYE ending in 2007. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-

Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On May 4, 2017, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated April 7, 2014, and April 15, 2014, corresponding to FYE ending in 2010. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on November 4, 2016, the Board received the group representative's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") dated May 12, 2016, corresponding to FYE ending in 2013. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

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

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent in interpreting the regulation because the Providers could bring suit in the D.C. Circuit.[4]

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

Board Members Participating:

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

For the Board:

10/19/2018

X Clayton J. Nix

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

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[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

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

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Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Supervisor – Cost Report Appeals
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RE: Jurisdictional Determination
McLaren Health Care 2013 LIP Post 1498R SSI Data Match CIRP Group
McLaren Health Care 2014 LIP Post 1498R SSI Data Match CIRP Group
McLaren Health Care 2011 LIP Medicare Advantage CIRP Group
McLaren Health Care 2013 LIP Medicare/Medicaid Fraction Part C Days CIRP Group
McLaren Health Care 2014 LIP Medicare/Medicaid Fraction Part C Days CIRP Group
McLaren Health Care 2010 LIP SSI Fraction Dual Eligible Days CIRP Group
McLaren Health Care 2011 LIP SSI Fraction Dual Eligible Days CIRP Group
McLaren Health Care 2012 LIP SSI Fraction Dual Eligible Days CIRP Group
McLaren Health Care 2013 LIP SSI Fraction Dual Eligible Days CIRP Group
McLaren Health Care 2014 LIP SSI Fraction Dual Eligible Days CIRP Group
Provider Nos.: 23-T041, 23-T105, 23-T141, 23-T207
FYEs: 9/30/2010, 12/31/2010, 9/30/2011, 9/30/2012, 9/30/2013, 9/30/2014
PRRB Case Nos.: 17-1429GC, 16-0955GC, 16-0837GC, 17-0543GC, 18-0339GC, 18-0340GC, 18-0341GC, 18-0138GC, 18-0140GC, 18-0139GC

Dear Ms. O'Brien Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2010, 2011, 2012, 2013, and 2014. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On October 26, 2017, and December 13, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated May 1, 2017, and July 6, 2017, corresponding to FYEs ending in 2013 and 2014. In its RFH, the Providers' list a single issue for appeal — the calculation of the Medicare percentage associated

with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On February 3, 2016, October 26, 2017, and December 13, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated August 12 and 21, 2015, December 23, 2015, May 1, 2017, and July 6, 2017, all corresponding to FYEs ending in 2011, 2013, and 2014. In its RFH, the Providers' list the same single issue for appeal — the calculation associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on January 28, 2016, November 28, 2016, May 4, 2017, October 26, 2017, and December 13, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated July 15, 2014, October 1 and 10, 2014, February 9, 2015, August 12 and 21, 2015, December 23, 2015, June 3 and 16, 2016, July 6, 2017, and May 1, 2017, corresponding to FYEs ending in 2010, 2011, 2012, 2013, 2014. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of

Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for the interpretation of this regulation because the Providers could bring suit in the D.C. Circuit.[4]

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

Board Members Participating:

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

For the Board:

10/19/2018

X Clayton J. Nix

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

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[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).
[3] *Mercy*, 891 F.3d at 1068.
[4] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Electronic Mail

OCT 19 2018

Stephanie A. Webster, Esq.
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: **Expedited Judicial Review Determination**

13-1833G	McKay 2006 SSI Ratio - Part C Days Group
13-2005GC	CHS NY 2006 DSH Medicaid Fraction Part C Days CIRP Group
13-2006GC	CHS NY 2006 DSH SSI Fraction Part C Days Group
15-2316G	McKay 2012 SSI Part C Days Group
15-2317G	McKay 2012 Medicaid Fraction Part C Days Group
16-0318G	McKay Post 9/30/2004 Medicaid Fraction Part C Days Group
16-1708G	McKay Post 09/30/2004 - 2007 Part C Days Group
16-1892	St. John's Hospital 2010
18-1402	Hurley Medical Center 2014

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' September 27, 2018 request for expedited judicial review (EJR) (received September 28, 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

[1] "SSI" is the acronym for "Supplemental Security Income."
[2] "DSH" is the acronym for "disproportionate share hospital."
[3] Providers' EJR Request at 4.

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

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

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

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

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

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

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

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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).

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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

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[15] *Id.*

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

[17] 69 Fed. Reg. 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.

> 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)

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

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[20] *Id.*
[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.

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]

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 2004-2013.

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

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[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.
[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.*

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen.*[32] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[33]

On August 21, 2008, new regulations governing the Board were effective.[34] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[35] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[36]

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

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[37] and $10,000 for the individual appeals.[38] The appeals were timely filed. The estimated amount in

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[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[33] *Bethesda at 1258-59.*
[34] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016)
[36] *Banner* at 142.
[37] *See* 42 C.F.R. § 405.1837.
[38] *See* 42 C.F.R. § 405.1835.

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

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2004-2013 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.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.[39]

Board's Decision Regarding the EJR Request

The Board finds that:

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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[39] On September 28, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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 group appeals cases, the Board hereby closes those cases. Because there are other issues under appeal in case numbers 16-1892 and 18-1402, those cases will remain open.

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Gregory H. Ziegler, CPA, CPC-A
Robert A. Everts, Esq.
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FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

Enclosures: Schedules of Providers

cc: Kyle Browning, NGS (Electronic Mail w/Schedules of Providers)
Danene Hartley, NGS (Electronic Mail w/Schedules of Providers)
Bryon Lamprecht, WPS(Electronic Mail w/Schedules of Providers)
Wilson Leong, (Electronic Mail w/Schedules of Providers)

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RE: Jurisdictional Determination
Premier Health Partners 2013 Rehab LIP Part C Days CIRP Group
Premier Health Partners 2014 LIP Medicare/Medicaid Part C Days CIRP Group
Premier Health Partners 2015 LIP Medicare/Medicaid Part C Days CIRP Group
Provider Nos.: 36-T051, 36-T076, 36-T174
FYEs: 12/31/2013, 12/31/2014, 12/31/2015
PRRB Case Nos.: 17-1506GC, 18-0035GC, 18-1134GC

Dear Ms. Griffin and Ms. Cummings:

This case involves Premier Health Partners' ("Premier") Inpatient Rehab Facilities ('IRF") appeals of the Medicare reimbursement for the fiscal years ending ("FYE") in 2013 through 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed Premier's documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear Premier's IRFs – Low Income Payment ("IRF-LIP") reimbursement issue, dismisses this issue from the instant appeals and, as this issue was the only issue, closes PRRB Case Nos. 17-1506GC, 18-0035GC, and 18-1134GC.

Pertinent Facts

On May 18, 2017, the Board received Premier's request for a hearing ("RFH") regarding the March 2, 2016, April 20, 2016, and April 27, 2016, Notices of Program Reimbursement ("NPR") for the cost reporting period ending on 12/31/2013. Its RFH, Premier lists a single issue for appeal — a challenge to the inclusion of inpatient days attributable to Medicare Advantage (MA) patients in both the numerator and the denominator of the SSI ratio used in the calculation of the IRF-LIP payment.

On October 10, 2017, the Board received Premier's RFH regarding its April 19, 2017, NPRs for the cost reporting period ending on 12/31/2014. In its RFH, Premier lists the same single issue

for appeal — a challenge to the inclusion of inpatient days attributable to MA patients in both the numerator and the denominator of the SSI ratio used in the calculation of the IRF-LIP payments.

Finally, on March 27, 2018, the Board received Premier's RFH regarding its October 11, 2017, NPRs for the cost reporting period ending on 12/31/2015. In its RFH, Premier lists the same single issue for appeal — a challenge to the inclusion of inpatient days attributable to MA patients in both the numerator and the denominator of the SSI ratio used in the calculation of the IRF-LIP payments.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Issue 1—Rehab Part C Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for IRFs. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

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

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

prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeal, the Premier seeks Board review of both components utilized by the Medicare Contractor to determine the LIP adjustments. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the appeals of the LIP adjustments and dismisses the issue in the instant appeals that challenge these adjustments. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent because the Premier could bring suit in the D.C. Circuit.[4]

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

Board Members Participating:

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

For the Board:

10/22/2018

X Charlotte Benson

Charlotte F. Benson
Board Member
Signed by: Charlotte Benson -A

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

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[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

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

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RE: Jurisdictional Determination
Ascension Health 2007-2015 Rehab Lip Appeals
Provider Nos.: *See Appendix A*
FYEs: 6/30/2007, 6/30/2008, 6/30/2009, 9/30/2009, 6/30/2011, 6/30/2012, 6/30/2013, 6/30/2014, 6/30/2015
PRRB Case Nos.: 15-2786GC, 15-2845GC, 15-2826GC, 17-1475GC, 18-1339GC, 17-1840GC, 15-2805GC, 15-2803GC, 16-2117GC, 16-2120GC, 16-2119GC, 17-2215GC, 17-2212GC

Dear Ms. O'Brien Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007, 2008, 2009, 2011, 2012, 2013, 2014, and 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On August 1, 2016, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2014. In its RFH, the Providers' list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On June 22, 2015, August 1, 2016, July 11, 2017, September 13, 2017, and May 31, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2011 through 2015. In its RFH, the Providers' list the same single issue for appeal — the calculation associated with the

Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on June 11 , 2015, June 16, 2015, June 22, 2015, August 1, 2016, May 3, 2017, and September 13, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2007 through 2015. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients

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

("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpreting the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[4]

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

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For the Board:

10/24/2018

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

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

---

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

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

Appendix A

15-2786GC	Ascension Health 2007 Rehab SSI Fraction Dual Eligible Days CIRP Grou
15-2845GC	Ascension 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
15-2826GC	Ascension 2009 Rehab Medicare Fraction Dual Eligible CIRP Group
17-1475GC	Ascension Health 2010 LIP SSI Dual Eligible Days CIRP
18-1339GC	Ascension Health 2011 Rehab LIP Medicare/Medicaid Medicare Advantage Days CIRP Group
17-1840GC	Ascension Health 2012 Rehab Medicare/Medicaid Fractions Medicare Advantage Days CIRP
15-2805GC	Ascension Health 2013 Rehab Medicare/Medicaid Fraction Part C Days CIRP Group
15-2803GC	Ascension Health 2013 Rehab SSI Fraction Dual Eligible CIRP Group
16-2117GC	Ascension Health 2014 LIP Post 1498R SSI Data Match CIRP
16-2120GC	Ascension Health 2014 Rehab LIP Medicare/Medicaid Fraction Part C Days CIRP
16-2119GC	Ascension Health 2014 Rehab LIP SSI Fraction Dual Eligible Days CIRP
17-2215GC	Ascension Health 2015 LIP Medicare/Medicaid Medicare Advantage Days CIRP Group
17-2212GC	Ascension Health 2015 LIP SSI Fraction Dual Eligible Days CIRP Group

Provider Nos.: 01-T011, 03-T010, 03-T011, 07-T028, 14-T258, 15-T010, 15-T088, 15-T100, 23-T019, 23-T117, 23-T165, 23-T195, 23-T197, 23-T257, 33-T047, 37-T018, 37-T114, 52-T136

FYEs: 6/30/2007, 6/30/2008, 6/30/2009, 9/30/2009, 6/30/2011, 6/30/2012, 6/30/2013, 6/30/2014, 6/30/2015

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RE: Jurisdictional Determination
LifePoint 2006-2015 Rehab LIP appeals
Provider Nos.: *See Appendix A*
FYEs: 2006-2015
PRRB Case Nos.: 15-2804GC, 15-2787GC, 18-1191GC, 15-2832GC, 15-2855GC, 18-0305GC, 17-0284GC, 18-0304GC, 18-1154GC, 18-1015GC, 15-3175GC, 18-1016GC, 17-1880GC, 15-3176GC, 15-3195GC, 16-2198GC, 16-2194GC, 16-2199GC, 17-2044GC, 17-2043GC, 17-2042GC

Dear Ms. O'Brien Griffin and Mr. Bloom:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, and 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On August 5, 2015, August 10, 2016, and August 15, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2011 through 2015. In its RFH, the Providers' list a single issue for appeal — the calculation of the Medicare percentage associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

On February 7, 2013, May 15, 2013, May 13, 2014, May 23, 2014, August 5, 2015, August 7, 2015, August 10, 2016, and August 15, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR")

corresponding to FYEs ending in 2008 through 2015. In its RFH, the Providers' list the same single issue for appeal — the calculation associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on December 10, 2012, February 7, 2013, June 11, 2015, August 5, 2015, August 10, 2015, October 27, 2016, August 16, 2017, and March 2, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2006 through 2015. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS'

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

establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpreting the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[4]

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

Board Members Participating:

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

For the Board:

10/24/2018

X Clayton J. Nix

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Chair
Signed by: Clayton J. Nix -A

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[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

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

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

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precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Appendix A

15-2804GC	*LifePoint 2006 Rehab SSI Fraction Dual Eligible Days CIRP Group*
15-2787GC	*LifePoint 2007 Rehab SSI Fraction Dual Eligible Days CIRP Group*
18-1191GC	*LifePoint 2008 Rehab LIP Medicare/Medicaid Part C Days CIRP Group*
15-2832GC	*LifePoint 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group*
15-2855GC	*LifePoint 2009 Rehab Medicare Fraction Dual Eligible Days CIRP Group*
18-0305GC	*LifePoint 2009 Rehab Medicare/Medicaid Fraction Part C Days CIRP Group*
17-0284GC	*LifePoint 2010 Rehab Medicare Fraction Dual Eligible Days Group*
18-0304GC	*LifePoint 2010 Rehab Medicare/Medicaid Fraction Part C Days CIRP Group*
18-1154GC	*LifePoint 2011 Rehab LIP Medicare/Medicaid Part C Days CIRP Group*
18-1015GC	*LifePoint 2011 Rehab LIP SSI Fraction Dual Eligible Days CIRP*
15-3175GC	*LifePoint 2011-2013 Rehab LIP SSI Data Match CIRP Group*
18-1016GC	*LifePoint 2012 Rehab LIP Medicare Fraction Dual Eligible Days CIRP Group*
17-1880GC	*LifePoint 2012 Rehab LIP Medicare/Medicaid Medicare Advantage Days CIRP*
15-3176GC	*LifePoint 2013 Rehab LIP Medicare Fraction Dual Eligible CIRP Group*
15-3195GC	*LifePoint 2013 Rehab LIP SSI/Medicaid Medicare Advantage Days CIRP Group*
16-2198GC	*LifePoint 2014 Rehab LIP Medicare Fraction Dual Eligible CIRP Group*
16-2194GC	*LifePoint 2014 Rehab LIP Medicare/Medicaid Fraction Medicare Advantage Days CIRP Group*
16-2199GC	*LifePoint 2014 Rehab LIP SSI Data Match CIRP Group*
17-2044GC	*LifePoint 2015 Rehab Medicare/Medicaid Fraction Part C Days CIRP Group*
17-2043GC	*LifePoint 2015 Rehab SSI Data Match CIRP Group*
17-2042GC	*LifePoint 2015 Rehab SSI Ratio Dual Eligible Days CIRP Group*

Provider Nos.: 01-T036, 03-T069, 03-T117, 15-T102, 18-T132, 19-T014, 19-T144, 19-T167, 19-T191, 23-T054, 34-T132, 39-T110, 44-T003, 44-T058, 44-T175, 44-T187, 45-3089, 45-T400, 45-T747, 49-T060, 49-T075, 51-T048, 53-T010

FYEs: 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Maureen O'Brien Griffin
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Danene Hartley
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: Jurisdictional Determination
Advocate 2009 LIP Medicare Fraction Dual Eligible Days CIRP
Advocate Health 2010 LIP Medicare Fraction Dual Eligible Days CIRP Group
Advocate Health 2011 Rehab LIP Medicare Fraction Dual Eligible Days CIRP Group
Advocate Health Care 2012 LIP SSI Fraction Dual Eligible Days CIRP Group
Advocate Health Care 2013 LIP SSI Ratio Dual Eligible Days CIRP Group
Provider Nos.: 14-T182, 14-T208, 14-T223
FYEs: 12/31/2009, 12/31/2010, 12/31/2011, 12/31/2012, 12/31/2013
PRRB Case Nos.: 16-2021GC, 16-1888GC, 16-2373GC, 17-0561GC, and 17-0533GC

Dear Ms. O'Brien Griffin and Ms. Hartley:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2009, 2010, 2011, 2012, and 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 17, 2016, June 22, 2016, September 6, 2016, November 21, 2016, and November 22, 2016, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2009 through 2013. In its RFH, the Providers' list the same single issue for appeal — the Medicare contractor's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, answers this question and clarifies what is shielded from review in its analysis of this issue.[1]

In *Mercy*, the Court describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The Court in *Mercy* affirmed the United States District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The Court of Appeals concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[3]

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

[2] *Mercy Hosp., Inc. v. Burwell*, No. 15-1236 (JDB), 2016 WL 4007072, at *8 (D.D.C. July 25, 2016).

[3] *Mercy*, 891 F.3d at 1068.

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare contractor to determine the Provider's LIP adjustment, namely its SSI—or Medicare—Ratio. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that the Court of Appeals decision in *Mercy* is controlling precedent for interpreting the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.[4]

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

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

10/24/2018

X Clayton J. Nix

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

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 29 2018

Stephanie A. Webster, Esq.
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: **Expedited Judicial Review Determination**

13-2070GC Geisinger 2007 SSI Part C Days Group
13-2072GC Geisinger 2007 Post 1498R Medicaid Fraction Part C Days Group
16-1091GC Geisinger 2007 Part C Days Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 10, 2018 request for expedited judicial review (EJR) (received October 11, 2018) for the above-referenced appeals. 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]

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

[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.*
[6] *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.[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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[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

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

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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.

[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.

> associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20] (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.[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]

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[20] *Id.*
[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.*

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]

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 year 2007.

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

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[28] 69 Fed Reg. 49,099 (Aug. 11, 2004).
[29] Providers' EJR Request at 5-6.
[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). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[33] *Bethesda* at 1258-59.

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[34] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda*. The Providers appealing from revised NPRs have an adjustment to the SSI percentage as required for Board jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[35] and $10,000 for the individual appeals.[36, 37] 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 fiscal year 2007 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.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request. [38]

Board's Decision Regarding the EJR Request

The Board finds that:

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[34] See 42 C.F.R. § 405.1889(b)(1) (2008).
[35] *See* 42 C.F.R. § 405.1837.
[36] *See* 42 C.F.R. § 405.1835.
[37] Case number 13-2072GC has only a single participant, although the hearing request was filed as a group appeal. The amount in controversy exceeds the $10,000 threshold for an individual appeal. The Board is electing to decide whether EJR is appropriate within the group appeal case number, but has treated the appeal as an individual appeal rather than a group appeal.
[38] On September 28, 2018, one of the Medicare contractors, Wisconsin Physicians Service ("WPS"), filed an objection to the EJR request in a number of cases identified in the EJR request. In its filing, WPS argues that the Board should deny the EJR request because the Board has the authority to decide the issue under appeal since it is not bound by the Secretary's regulation that the federal district court vacated in *Allina*. The Board's explanation of its authority regarding this issue addresses the arguments set out in WPS' challenge.

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

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

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

4) it is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), 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 year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

Clayton J. Nix, Esq.
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Chair

Enclosures: Schedules of Providers

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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OCT 31 2018

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RE: **Expedited Judicial Review Determination**

13-3945GC	MHS 2007 DSH SSI Fraction Part C Days Group
13-3869GC	MHS 2008 DSH SSI Fraction Part C Days Group
14-0456GC	MHS 2009 DSH SSI Fraction Part C Days Group
14-3588GC	MHS 2010 DSH SSI Fraction Part C Days Group
15-2023GC	MHS 2011 DSH SSI Fraction Part C Days Group
15-2067GC	MHS 2012 DSH SSI Fraction Part C Days Group
16-0981GC	MHS 2013 DSH SSI Fraction Part C Days Group

Dear Ms. Marsden:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' October 15, 2018 requests for expedited judicial review (EJR) (received October 16, 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 the Providers' DSH payments were understated because there were calculated using a SSI fraction that improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

[1] Providers' EJR Requests at 1.

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

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

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

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

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

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

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

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

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

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

Medicare Advantage Program

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

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

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

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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.

> 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. However, the Providers point out, the decision is not binding in actions by other hospitals. Further, the Secretary has not acquiesced to that decision.

Providers' Requests for EJR

The Providers assert that pursuant to the Medicare statute, Medicare Part C days should not be included in either the numerator or denominator of the SSI fraction. In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), hospital inpatients who are 'entitled to benefits under Part A' are to be included in the SSI fraction, with all such patients in the denominator and those who are also entitled to SSI in the numerator. Patients enrolled in a Medicare Part C plan may be 'eligible' for Part A, but are not 'entitled' to Part A benefits during the months when they have given up their Part A entitlement to enroll in Part C. Accordingly they do not belong in the SSI fraction.

The Providers contend that the Secretary's policy has been inconsistent regarding the treatment for DSH purposes of inpatient days relating to individuals enrolled in Medicare Part C during their hospital stays. In 2003, the Secretary "proposed to clarify" that Medicare Part C days

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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).

should not be included in the [SSI] fraction." In addition, the Secretary[21] proposed to permit hospitals to counted Medicaid-eligible days in the numerator of the Medicaid fraction. However, this proposal was not finalized that year.[22] In 2004, the Secretary adopted a policy to included Medicare Part C Days in the SSI fraction and exclude those dual-eligible days from the numerator of the Medicaid fraction and stated that the regulations to reflect this policy.[23] However, the regulation was not revised until 2007 when the Secretary stated that she had "inadvertently" failed to revise the regulation earlier. The Providers believe this was done without notice and comment required by 5 U.S.C. § 551 *et seq.* Further, the regulation does not comport with the D.C. Circuit Court decision in *Allina Health Services v. Price*[24] which held that the 2004 rule was invalid because HHS had changed its reimbursement formula without notice providing an opportunity for comment.[25]

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 final IPPS rule that the Board lacks the authority to grant. The Providers maintain that "the Board is required to comply with all regulations issued by the Secretary under the Social Security Act, and is therefore bound to uphold the inclusion of Part C days SSI fraction issue, the Board lacks the authority to make any changes to CMS's policy."[26] 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 these EJR requests have filed appeals involving fiscal years 2007-2013.

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-

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[21] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[22] *See* 68 Fed. Reg. 45,346, 45,422 (Aug. 1, 2003).
[23] 69 Fed. Reg. at 49,099 (Aug. 11, 2004).
[24] 863 F.3d 937 (D.C. Cir. 2017).
[25] *Id.* at 938.
[26] Providers' EJR Requests at 4-5.

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen (Bethesda).*[27] 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.[28]

On August 21, 2008, new regulations governing the Board were effective.[29] 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).*[30] 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.[31]

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 any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[32] The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[27] 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.).
[28] *Bethesda at 1258-59.*
[29] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[30] 201 F. Supp. 3d 131 (D.D.C. 2016)
[31] *Banner* at 142.
[32] See 42 C.F.R. § 405.1889(b)(1) (2008).

The Board has determined that participants involved with the instant EJR requests are governed by the decision in *Bethesda* or CMS Ruling CMS 1727-R. The Providers which filed appeals from revised NPRs have adjustments to the SSI percentage, as required for jurisdiction. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[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 Analysis Regarding the Appealed Issue

The group appeals in these EJR requests span fiscal years 2007- 2013 thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Requests

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' requests for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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