DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Maureen O'Brien Griffin
Hall, Render, Killian, Heath & Lyman, P.C.
500 N. Meridian St., Suite 400
Indianapolis, IN 46204

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

RE: Jurisdictional Determination
Community Health Network 2007 Rehab SSI Fraction Dual Eligible Days Group
Community Health Network 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Community Health Network 2009 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Provider Nos.: 15-T074, 15-3039
FYEs: 12/31/2007, 12/31/2008, 12/31/2009
PRRB Case Nos.: 15-2801GC, 15-2835GC, 15-2831GC

Dear Ms. Griffin and Mr. Lamprecht:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007, 2008, and 2009. 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 11, 2015, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated February 11, 2013, and February 19, 2013, all corresponding to FYE ending in 2007. In its RFH, the Providers' list the same single issue for appeal — the Medicare Administrative Contractor's (MAC) 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, 2015, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated February 27, 2013, and April 15, 2013, corresponding to FYE ending in 2008. In its RFH, the Providers' list the same single issue

for appeal — the MAC'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 June 16, 2015, the Board received the group representative's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") dated March 18, 2013, and May 24, 2013, corresponding to FYE ending in 2009. In its RFH, the Providers' list the same single issue for appeal — the MAC'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 in 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/5/2018

X Clayton J. Nix

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

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

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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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Pam VanArsdale
Appeals Lead
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: Jurisdictional Determination
Care New England Health System 2007 Rehab SSI Fraction Dual Eligible Days CIRP Group
Care New England Health 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Care New England Health 2009 Rehab Medicare Fraction Dual Eligible CIRP Group
Care New England 2012 Rehab LIP Medicare/Medicaid Fraction Part C Days CIRP
Care New England 2012 Rehab LIP SSI Fraction Dual Eligible Days CIRP Group
Care New England 2013 Rehab LIP Medicare/Medicaid Fraction Part C Days CIRP Group
Care New England 2013 Rehab LIP SSI Fraction Dual Eligible Days CIRP Group
Provider Nos.: 41-T001, 41-T009,
FYEs: 9/30/2007, 9/30/2008, 9/30/2009, 9/30/2012, 9/30/2013
PRRB Case Nos.: 15-2828GC, 15-3220GC, 15-3214GC, 16-2044GC, 16-2040GC, 15-2839GC, 15-2848GC

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

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007, 2008, 2009, 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 14, 2015, and July 14, 2016, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2012 and 2013. 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").

Additionally, on June 11, 2015, June 16, 2015, August 14, 2015, and July 14, 2016, 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 2013. In its RFH, the Providers' list the same single issue for appeal — the Medicare Administrative Contractor's (MAC) 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 in 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/5/2018

X Clayton J. Nix

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

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

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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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500 N. Meridian St., Suite 400
Indianapolis, IN 46204

Cecile Huggins
Palmetto GBA
Supervisor, Provider Cost Report Appeals
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202

RE: Jurisdictional Determination
Capella Healthcare 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Capella Healthcare 2009 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Capella Healthcare 2010 LIP SSI Fraction Dual Eligible Days CIRP
Provider Nos.: 04-T078, 37-T025, 44-T151, 44-T200
FYEs: 4/30/08, 9/30/08, 12/31/2008, 4/30/2009, 12/31/2009, 4/30/2010, 8/31/2010, 9/30/2010
PRRB Case Nos.: 15-2842GC, 15-2844GC, 16-2211GC

Dear Ms. Elias and Ms. Huggins:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2008, 2009, and 2010. 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 16, 2015, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated February 13, 2013, May 13, 2013, and June 5, 2013, all corresponding to FYE ending in 2008. In its RFH, the Providers' list the same single issue for appeal — the Medicare Administrative Contractor's (MAC) 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 August 22, 2013, the Board received the group representative's request for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") dated February 26, 2013, March 8, 2013, and June 5, 2013, corresponding to FYE ending in 2009. In its RFH, the

Providers' list the same single issue for appeal — the MAC'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 August 5, 2016, the Board received the group representative's request for a hearing ("RFH") regarding a Notice of Program Reimbursement ("NPR") dated December 4, 2012, August 30, 2013, and February 11, 2016, corresponding to FYE ending in 2010. In its RFH, the Providers' list the same single issue for appeal — the MAC'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 in 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
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/5/2018

X Clayton J. Nix

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

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

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

RE: Jurisdictional Determination
Baptist Health Arkansas 2006 LIP SSI Dual Eligible CIRP Group
Baptist Health (Arkansas) 2007 Rehab SSI Fraction Dual Eligible CIRP Days Group
Baptist Health (Arkansas) 2012 LIP Dual Eligible Days CIRP
Baptist Health (Arkansas) 2013 SSI LIP Dual Eligible Days CIRP Group
Baptist Health (Arkansas) 2014 SSI LIP Dual Eligible Days CIRP Group
Baptist Health Arkansas 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
Baptist Health Arkansas 2010 LIP SSI Dual Eligible Days CIRP
Baptist Health Arkansas 2011 LIP SSI Dual Eligible Days CIRP
Provider Nos.: 04-T036, 04-3026
FYEs: 12/31/06, 12/31/07, 12/31/08, 12/31/10, 12/31/11, 12/31/12, 12/31/13, 12/31/14
PRRB Case Nos.: 16-1870GC, 15-2790GC, 17-1789GC, 18-0044GC, 18-0604GC, 15-2833GC, 17-1472GC, 17-1524GC

Dear Ms. Elias and Mr. Kamal:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2006 to 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 June 11, 2015, June 16, 2015, January 25, 2016, May 15, 2017, May 17, 2017, June 30, 2017, October 5, 2017, and January 18, 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 to 2014. In their RFHs, the Providers' list the same single issue for appeal — the Medicare Administrative 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. 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) 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

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[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[2] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93 (D.D.C. 2016).

"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 relevant statutory provisions 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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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/6/2018

X Clayton J. Nix

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

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

[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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Russell Kramer
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: Jurisdictional Decision
QRS BJC 2014 Uncompensated Care Distribution Pool CIRP Group
PRRB Case 18-1513GC

Dear Mr. Kramer,

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

Pertinent Facts:

The Providers filed their appeal request challenging the Final Rule in the Federal Register issued on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2014 Rates.

The Provider contends that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size pool of the UCC payments available for distribution to DSH eligible hospitals for FY 2014. More specifically, the Provider argues that the notice and comment rulemaking requirements were violated, and that inaccurate or unsubstantiated data was used by CMS in its calculations.

The Medicare Contractor has filed a jurisdictional challenge for this appeal, arguing that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.FR. § 412.106(g)(2).

Board's Decision:

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

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

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

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

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

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

---

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

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

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

[4] 830 F.3d at 517.

[5] *Id.* at 519.

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:

11/16/2018

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

RE: Jurisdictional Decision
Montefiore Health System 2014 DSH Uncompensated Care Payment Group
PRRB Case Number 18-0472GC

Dear Ms. Webster,

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

Pertinent Facts:

The Providers filed their Group Appeal Request challenging the Final Rule in the Federal Register issued on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2014 Rates. The Providers in the group are each appealing a Notice of Program Reimbursement.

The Providers are challenging the procedural and substantive validity of the Secretary's determination of their disproportionate share hospital ("DSH") payment amounts for uncompensated care costs for Federal Fiscal Year 2014. The Providers contend that the Secretary's determinations and rule are arbitrary, capricious, reflect an abuse of discretion, are not based upon substantial evidence, violate the notice and comment rulemaking requirements and are otherwise contrary to law.

The Medicare Contractor noted in its 30 day letter that it believes this issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3), but has not filed a formal jurisdictional challenge in this appeal.

Board's Decision:

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

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

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

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

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

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

---

[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631, 50634 (Aug. 19, 2013).
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d at 517.
[5] *Id.* at 519.

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:

11/16/2018

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

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

RE: Jurisdictional Decision
Montefiore Health System 2014 DSH Uncompensated Care Factor 3 CIRP Group
PRRB Case 18-1519GC

Dear Ms. Webster,

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

Pertinent Facts:

The Providers filed their Group Appeal Request challenging the calculations and data used for the Final Rule in the Federal Register issued on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2014 Rates. The Providers are each appealing a Notice of Program Reimbursement.

The Providers are challenging the calculations and data used by the Secretary to determine their disproportionate share hospital ("DSH") payment amounts for uncompensated care costs for Federal Fiscal Year 2014. The Providers contend that the Secretary's determinations and rule are arbitrary, capricious, are not based upon substantial evidence, are otherwise contrary to law, and unlawfully fail to reflect the best available data.

The Medicare Contractor noted in its 30 day letter that it believes this issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3), but has not filed a formal jurisdictional challenge in this appeal.

Board's Decision:

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

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

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

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

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

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

---

[1] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631, 50634 (Aug. 19, 2013).
[2] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[2]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).
[3] 89 F. Supp. 3d 121 (D.D.C. 2015).
[4] 830 F.3d at 517.
[5] *Id.* at 519.

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:

11/16/2018

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Albert W. Shay
Morgan, Lewis & Bockius LLP
1111 Pennsylvania Avenue, NW
Washington, DC 20004

RE: Jurisdictional Decision
Morgan Lewis 2013 Uncompensated Care Group
PRRB Case Number 16-2562G

Dear Mr. Shay,

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

Pertinent Facts:

The Providers filed their Group Appeal Request challenging the Final Rule in the Federal Register issued on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2014 Rates. The Providers in the group are each appealing a Notice of Program Reimbursement.

The Providers state the Final Rule is invalid. They argue that CMS's determination of their DSH uncompensated care payment for FY 2014, the choice of data used to determine that amount, CMS's calculations, and the rules governing those determinations are all *ultra vires*, arbitrary and capricious, not based on substantial evidence, and otherwise contrary to law.

The Medicare Contractor has filed a jurisdictional challenge in this appeal arguing that 42 U.S.C. § 1395ww(r) bars administrative and judicial review of the uncompensated DSH payment issue, and therefore the Board lacks subject matter jurisdiction over this matter. The Providers argue that the statutory bar should be viewed narrowly and is not applicable to this issue. Furthermore, they argue that, included in their DSH payment challenge, is a "sub-component" issue related to the methodology in counting Providers' Part C days.

Board's Decision:

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

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

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

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

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

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this group appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal,[6] the Board hereby closes the referenced group appeal and removes it from its docket.

---

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

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

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

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

[5] *Id.* at 519.

[6] Providers assert that there is a "sub-component" issue related to the methodology in counting Providers' Part C days. The formation of this Optional Group Appeal was predicated on the existence of a single common issue. *See* 42 C.F.R.

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:

11/16/2018

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Pam VanArsdale, National Government Services, Inc. (J-K)

§ 405.1837(a)(2) and PPRB Rules 13 and 8. Nevertheless, the counting of Part C days is an integral part of the methodology and calculations used in the Secretary's estimates for uncompensated care, which are exempt from administrative review. 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

NOV 16 2018

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

RE: **Expedited Judicial Review Determination**

13-2277GC	SWC Care New England 2007 DSH Medicaid Fraction Part C Days Group
13-2279GC	SWC Care New England 2007 DSH SSI Fraction Part C Days Group
13-3285GC	SWC Care New England 2006 DSH SSI Fraction Part C Days Group
13-3288GC	SWC Care New England 2006 DSH Medicaid Fraction Part C Days Group
13-3819GC	SWC Care New England 2008 Medicaid Fraction Medicare Advantage Days Group
13-3820GC	SWC Care New England 2008 DSH SSI Fraction Part C Days Group
14-2289GC	SWC Care New England 2009 DSH Medicaid Fraction Part C Days Group
14-2290GC	SWC Care New England 2009 DSH SSI Fraction Part C Days Group
15-0668GC	SWC Care New England 2010 SSI Fraction Part C Days Group
15-0669GC	SWC Care New England 2010 Medicaid Fraction Part C Days Group
15-0920GC	SWC Care New England 2011 DSH SSI Fraction Part C Days Group
15-0921GC	SWC Care New England 2011 Medicaid Fraction Part C Days Group

Dear Mr. Newell:

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

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.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total 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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[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(l).
[7] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[9] 42 C.F.R. § 412.106(b)(2)-(3).
[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 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:

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

> . . . 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.

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.

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[16] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[17] 69 Fed. Reg. at 49,099.
[18] *Id.*
[19] 72 Fed. Reg. 47,130, 47,384 (August 22, 2007).
[20] 746 F. 3d 1102 (D.C. Cir. 2014).

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.[21]

In *Allina*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."[22] The Providers point out that because the Secretary has not acquiesced to the decision, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

Decision of the Board

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

Jurisdictional Determination

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

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

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[21] 69 Fed. Reg. at 49,099.
[22] *Allina* at 1109.
[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.).

that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[24]

On August 21, 2008, new regulations governing the Board were effective.[25] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[26] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[27]

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

The Board has determined that the participants appeal of the Part C days are self-disallowed costs which are governed by the decision in *Bethesda* (FYE 2007 and 2008) or CMS Ruling 1727-R (FYE 2009-2011). In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal and the participants' appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involves the fiscal years 2006-2011, thus the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's FFY 2005 IPPS rule being challenged. The Board recognizes that the D.C. Circuit vacated this regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.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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[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).
[27] *Banner* at 142.

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

FOR THE BOARD:

Gregory H. Ziegler for

Clayton J. Nix, Esq.
Chair

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (Electronic delivery w/Schedule of Providers)
Wilson Leong, FSS (Electronic delivery w/Schedules of Providers)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: Jurisdictional Decision
Akin Gump FY 2018 Uncompensated Care DSH Group Cases
PRRB Case 18-0574GC et al. (See Attached Listing of Appeals)

Dear Ms. Webster,

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

Pertinent Facts:

The Providers all filed their appeal requests from the Final Rule issued in the Federal Register issued on August 14, 2017: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2018 Rates.[1]

The Providers are challenging the procedural and substantive validity of the Secretary's determination of their disproportionate share hospital ("DSH") payment amounts for uncompensated care costs for Federal Fiscal Year 2018. The Providers contend that the Secretary's determinations and rule are arbitrary, capricious, reflect an abuse of discretion, are not based upon substantial evidence, violate the notice and comment rulemaking requirements and are otherwise contrary to law.

The Medicare Contractor has filed a jurisdictional challenge in one of the appeals.[2]

Board's Decision:

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

[1] 82 Fed. Reg. 37990 (Aug. 14, 2017).
[2] PRRB Case No. 18-0574GC. The grounds for the challenge are generally that the Board does not have jurisdiction over the DSH payment issue because 42 U.S.C. § 1395ww(r)(3) precludes its administrative review. *See generally* Medicare Administrative Contractor's Jurisdictional Challenge (April 12, 2018).

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[3]
(B) Any period selected by the Secretary for such purposes.

Further, the D.C. Circuit Court[4] upheld the D.C. District Court's decision[5] that there is no judicial or administrative review of uncompensated care DSH payments. In *Tampa General*, the Provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The Provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The Provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[6] The Court also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[7]

The Board finds that the same findings are applicable to the Providers' challenge to their 2018 uncompensated care payments. As in *Tampa General*, the Providers here are challenging the calculation of the amount they received for uncompensated care for FY 2018. The Board finds that in challenging the Medicare Contractor's calculation of their uncompensated care final payment amounts, the Providers are seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board therefore finds that the Providers are challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well.

The Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in the group appeals referenced in the attached listing because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in each appeal, the Board hereby closes the referenced group appeals and removes them from its docket.

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[3] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). *See* 82 Fed. Reg. at 38192-93, 38196-97, 38200-01 (summarizing the factors and methods for determining each one which were originally adopted in 78 Fed. Reg. 50496, 50627, 50631, 50634 (Aug. 19, 2013)).

[4] *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.*[4]("*Tampa General*"), 830 F.3d 515 (D.C. Cir. 2016).

[5] 89 F. Supp. 3d 121 (D.D.C. 2015).

[6] 830 F.3d 515, 517.

[7] *Id.* at 519.

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:

11/20/2018

X Clayton J. Nix

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

Enclosures: Listing of Appeals

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5, J-8)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Mounis Kamal, Novitas Solutions, Inc. (J-H)
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)
John Bloom, Noridian Healthcare Solutions (J-F)
Pam VanArsdale, National Government Srevices, Inc. (J-K)
Danene Hartley, National Government Services, Inc. (J-6)
Geoff Pike, First Coast Services Options, Inc. (J-N)
Cecile Huggins, Palmeto GBA (J-J)
Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Judith Cummings, CGS Administrators (J-15)

Akin Gump FY 2018 Uncompensated Care DSH Group Cases

18-0574GC	Beaumont Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0624GC	Geisinger Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0627GC	Methodist Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0683GC	INTEGRIS Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0684GC	Greenville Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0685GC	Legacy Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0686GC	Memorial Hermann 2018 DSH Uncompensated Care Payment CIRP Group
18-0687GC	Methodist Hospital System 2018 DSH Uncompensated Care Payment CIRP Group
18-0688GC	Mount Sinai Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0689GC	Einstein Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0690GC	Allina Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0691GC	Baptist Health South Florida 2018 DSH Uncompensated Care Payment CIRP Group
18-0692GC	Catholic Health Initiatives 2018 DSH Uncompensated Care Payment CIRP Group
18-0693GC	Covenant Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0694G	Akin Gump 2018 DSH Uncompensated Care Payment Group
18-0695GC	Steward Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0696GC	Montefiore Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0697GC	Northwell Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0700GC	Duke University 2018 DSH Uncompensated Care Payment CIRP Group
18-0711GC	RWJ Barnabas Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0747GC	Orlando Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0748GC	UMass Memorial Health Care 2018 DSH Uncompensated Care Payment CIRP Group
18-0749GC	United Health Services 2018 DSH Uncompensated Care Payment CIRP Group
18-0750GC	Univ. of Rochester Medical Ctr 2018 DSH Uncompensated Care Payment CIRP Group
18-0797GC	UPMC 2018 DSH Uncompensated Care Payments CIRP Group
18-0798GC	Verity Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0811GC	Wake Forest Baptist Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0812GC	Premier Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0813GC	Saint Francis Health System 2018 DSH Uncompensated Care Payment CIRP Group
18-0814GC	Sanford Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0815GC	St. Elizabeth Healthcare 2018 DSH Uncompensated Care Payment CIRP Group
18-0816GC	Trinity Health 2018 DSH Uncompensated Care Payment CIRP Group
18-0817GC	Rochester Regional Health Sys 2018 DSH Uncompensated Care Payment CIRP Group

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RE: Jurisdictional Determination
Community Health Systems 2006-2014 Rehab Lip Appeals
Provider Nos.: Various
FYEs: 2006 - 2009, 2011 - 2015
PRRB Case Nos.: 17-0919GC, 17-1912GC, 17-1099GC, 17-1723GC, 15-2814GC, 15-2847GC, 16-0594GC, 17-1498GC, 17-1525GC, 15-3092GC, 15-3472GC, 16-2391GC, 17-1913GC, 17-1915GC

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

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYEs") in 2006, 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 decision of the United States Court of Appeals for the District of Columbia Circuit in *Mercy Hospital, Inc. v. Azar* ("*Mercy*"), 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 July 24, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYE 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 1, 2017, February 14, 2017, and July 27, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs 2006 through 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 June 12, 2015, June 17, 2015, August 3, 2015, September 29, 2015, December 8, 2015, September 8, 2016, May 15, 2017, May 18, 2017, June 23, 2017, July 24, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs 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 IRFs. Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Court of Appeals' decision in *Mercy*, 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 D.C. Court of Appeals in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[2] The D.C. 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 D.C. Court of Appeals decision in *Mercy* is controlling precedent 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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[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

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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

17-0919GC	Community Health System 2006-2009 Rehab LIP Post 1498R Data Match CIRP
17-1912GC	Community Health Systems 2010-2011 Rehab Post 1498R SSI Data Match CIRP
17-1099GC	Community Health Systems 2012-2014 Rehab LIP Post 1498R Data Match CIRP
17-1723GC	Community Health Systems 2015 LIP SSI Fraction Dual Eligible Days CIRP Group
15-2814GC	Community Healthcare System 2007 Rehab SSI Fraction Dual Eligible Days CIRP Group
15-2847GC	Community Healthcare System 2008 Rehab Medicare Fraction Dual Eligible Days CIRP Group
16-0594GC	Community Healthcare System 2009 LIP Rehab Medicare Fraction Dual Eligible Days CIRP Group
17-1498GC	Community Healthcare System 2010 LIP SSI Fraction Dual Eligible Days CIRP
17-1525GC	Community Healthcare System 2011 LIP SSI Fraction Dual Eligible Days CIRP
15-3092GC	Community Healthcare System 2012 Rehab LIP SSI Fraction Dual Eligible CIRP Group
15-3472GC	Community Healthcare System 2013 Rehab LIP SSI Fraction Dual Eligible Days CIRP
16-2391GC	Community Healthcare System 2014 Rehab LIP SSI Fraction Dual Eligible Days CIRP Group
17-1913GC	Community Healthcare System 2015 LIP Medicare Fraction Dual Eligible Days CIRP Group
17-1915GC	Community Healthcare System 2015 LIP Medicare/Medicaid Medicare Advantage Days CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: Jurisdictional Decision
QRS CHS 2014 Uncompensated Care Distribution Pool CIRP Group
PRRB Case 18-0113GC

Dear Mr. Ravindran,

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

Pertinent Facts:

The Providers filed their Group Appeal Request challenging the Final Rule in the Federal Register issued on August 19, 2013: the Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2014 Rates.[1] The Providers are each appealing a Notice of Program Reimbursement.

The Providers contend that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size pool of the UCC payments available for distribution to DSH eligible hospitals for FY 2014. More specifically, the Providers argue that the notice and comment rulemaking requirements were violated, and that inaccurate or unsubstantiated data was used by CMS in its calculations and methodology established in the Final Rule.

The Medicare Contractor has filed a jurisdictional challenge for this appeal, arguing that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.FR. § 412.106(g)(2).

Board's Decision:

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

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

[1] 78 Fed. Reg. 50496 (Aug. 19, 2013).
[2] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who

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

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

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

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

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

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are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. at 50627, 50631 and 50634.

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

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

[5] 830 F.3d at 517.

[6] *Id.* at 519.

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:

11/30/2018

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