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*
Catholic Health NY 2014 Uncompensated Care CIRP Group
PRRB Case No. 18-0142GC

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 ("UCC") Payment issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers filed their appeal requests from Notices of Program Reimbursement challenging the Centers for Medicare and Medicaid Services ("CMS") calculation of the UCC payments care as outlined in 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 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.

To date, the Medicare Contractor has not filed a jurisdictional challenge or otherwise noted any jurisdictional impediments for 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:

[1] 78 Fed. Reg. 50496 (Aug. 19, 2013).

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

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

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

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:

12/11/2018

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

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

RE: *Jurisdictional Decision*
QRS HMA 2014 DH Uncompensated Care Payment CIRP Group
PRRB Case No. 17-0573GC

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.

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:

[1] 78 Fed. Reg. 50496 (Aug. 19, 2013).

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

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

Further, the D.C. Circuit Court[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.

---

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
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Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

12/11/2018

X Clayton J. Nix

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

cc:

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Byron Lamprecht, WPS Government Health Administrators (J-5)

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Indianapolis, IN 46206

RE: Jurisdictional Determination
Hall Render 2006-2016 Rehab Lip Appeals
Provider Nos.: Various
FYEs: 2006 - 2009, 2011 - 2015
PRRB Case Nos.: Please see list at Appendix A

Dear Ms. O'Brien Griffin, Mr. Lamprecht, Ms. Cummings, Ms. Polson, and Ms. Hartley:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2006 through 2016. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the United States Court of Appeals, District of Columbia Circuit's decision in *Mercy Hospital, Inc. v. Azar*, on June 8, 2018. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On June 17, 2015, August 31, 2015, September 11, 2015, November 24, 2015, November 25, 2015, January 15, 2016, August 3, 2016, October 27, 2016, and July 24, 2017, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 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 June 1, 2015, June 17, 2015, June 24, 2015, July 2, 2015, December 14, 2015, March 7, 2016, July 12, 2016, July 27, 2016, August 1, 2016, August 3, 2016, August 4, 2016, August 10, 2016, May 26, 2017, June 23, 2017, June 26, 2017, October 25, 2017, October 30, 2017, March 9, 2018, May 29, 2018, July 20, 2018, and September 7, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2006 through 2016. In its RFH, the Providers' list the same single issue for appeal — the calculation associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Finally, on June 11, 2015, June 16, 2015, June 17, 2015, February 17, 2016, February 25, 2016, March 1, 2016, April 27, 2016, August 4, 2016, October 13, 2016, May 5, 2017, May 18, 2017, May 29, 2018, June 12, 2018, and September 7, 2018, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR") corresponding to FYEs ending in 2006 through 2016. In its RFH, the Providers' list the same single issue for appeal — the Intermediary's exclusion of dual eligible days associated with the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

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

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

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

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

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

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

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

[4] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the 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).

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:

12/14/2018

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

Appendix A

16-2172G	Hall Render 2006 Rehab LIP Medicare/Medicaid Part C Days Group
15-2879G	Hall Render 2006 Rehab SSI Fraction Dual Eligible Days Group
16-1943G	Hall Render 2006-2007 LIP Rehab Post 1498R SSI Data Match Group II
18-0302G	Hall Render 2007 Rehab LIP Medicare/Medicaid Part C Days Group II
16-2152G	Hall Render 2007 Rehab Medicare/Medicaid Part C Days Group
15-2865G	Hall Render 2007 Rehab SSI Fraction Dual Eligible Days Group
16-2221G	Hall Render 2008 Post 1498R Rehab LIP DSH SSI Data Match Group
16-2196G	Hall Render 2008 Rehab LIP Medicare/Medicaid Part C Days Group
18-0300G	Hall Render 2008 Rehab LIP Medicare/Medicaid Part C Days Group II
15-2864G	Hall Render 2008 Rehab Medicare Fraction Dual Eligible Optional Group
16-1494G	Hall Render 2009 LIP Medicare Fraction Dual Eligible Days Group II
16-2173G	Hall Render 2009 Rehab LIP Medicare/Medicaid Part C Days Group
17-0145G	Hall Render 2009 Rehab LIP Medicare/Medicaid Part C Days Group II
18-1045G	Hall Render 2009 Rehab LIP Medicare/Medicaid Part C Days Group III
15-2852G	Hall Render 2009 Rehab Medicare Fraction Dual Eligible Group
15-2880G	Hall Render 2009 Rehab Medicare/Medicaid Fraction Part C Days Group II
16-0298G	Hall Render 2009 Rehab Post 1498R Data Match Group
17-0276G	Hall Render 2009-2012 Rehab LIP Post 1498-R Data Match Group
16-1423G	Hall Render 2010 LIP Medicare/Medicaid Fraction Part C Days Group
15-3298G	Hall Render 2010 Post 1498R Rehab Data Match Group
17-1748G	Hall Render 2010 Rehab LIP Part C Days Group III
16-1493G	Hall Render 2010 Rehab Medicare Fraction Dual Eligible Days Group
17-1443G	Hall Render 2010 Rehab Medicare Fraction Dual Eligible Days Group II
15-2812G	Hall Render 2010 Rehab Medicare/ Medicaid Fraction Part C Days Group
16-1134G	Hall Render 2011 LIP Dual Eligible Days Group
17-1517G	Hall Render 2011 LIP Medicare Fraction Dual Eligible Days Group III
16-1412G	Hall Render 2011 LIP SSI Fraction Dual Eligible Days Group II
15-3412G	Hall Render 2011 Post 1498R Rehab Data Match Group
18-0137G	Hall Render 2011 Rehab LIP Medicare/Medicaid Part C Days Group III
16-2157G	Hall Render 2011 Rehab Medicare/Medicaid Part C Days Group II
15-2887G	Hall Render 2011 Rehab SSI Fraction Part C Days Group
17-0155G	Hall Render 2012 LIP SSI Fraction Dual Eligible Days Group II
16-2293G	Hall Render 2012 Rehab LIP Medicare/ Medicaid Part C Days Group II
17-1759G	Hall Render 2012 Rehab LIP Medicare/ Medicaid Part C Days Group III
15-3058G	Hall Render 2012 Rehab Medicare/Medicaid Fraction Part C Days Group
15-3059G	Hall Render 2012 Rehab Post 1498R SSI Data Match Group
15-3062G	Hall Render 2012 Rehab SSI Fraction Dual Eligible Group
16-2153G	Hall Render 2013- 2014 LIP Post 1498R SSI Data Match Group

16-1526G	Hall Render 2013 LIP Medicare/Medicaid Fraction Part C Days Group
16-1915G	Hall Render 2013 LIP SSI Fraction Dual Eligible Days Group
18-1356G	Hall Render 2013 LIP SSI Fraction Dual Eligible Days Group II
17-1555G	Hall Render 2013 Rehab LIP Part C Days Group II
16-2156G	Hall Render 2014 LIP Medicare/Medicaid Fraction Part C Days Group
18-1327G	Hall Render 2014 LIP Medicare/Medicaid Fraction Part C Days Group II
18-1326G	Hall Render 2014 LIP SSI Fraction Dual Eligible Days Group II
18-1355G	Hall Render 2014 Rehab LIP Post 1498R SSI Data Match Group II
16-2151G	Hall Render 2014 Rehab LIP SSI Fraction Dual Eligible Days Group
18-1560G	Hall Render 2015 LIP Medicare/Medicaid Fraction Part C Days Group
17-1946G	Hall Render 2015 LIP SSI Post 1498R Data Match Group
18-1807G	Hall Render CY 2016 Rehab SSI Ratio Dual Eligible Days Group
18-1808G	Hall Render CY 2016 Rehab Part C Days Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Electronic Mail

Barbara Viskochil
Director, Medicare & Medicaid Services
University of Utah Hospital and Clinics
127 South 500 East, Suite 200
Salt Lake City, UT 84102

John Bloom, Appeals Coordinator
Noridian Healthcare Solutions (JF)
JF Provider Audit Appeals
P.O. Box 6722
Fargo, ND 58108 6722

RE: University of Utah Hospital and Clinics
Provider No. 46-0009
FYE 06/30/2015
PRRB Case No. 19-0178

Dear Ms. Viskochil and Mr. Bloom:

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

Pertinent Facts:

The Notice of Program Reimbursement (NPR) for University of Utah Hospital and Clinics was issued by the Medicare Contractor on March 27, 2018.

University of Utah Hospital and Clinics filed an individual appeal on October 1, 2018. The appeal request did not include a copy of the NPR, nor did it include a calculation of the reimbursement impact.

The Board established case number 19-0178 and issued an acknowledgement letter via e-mail on November 29, 2018.

Board Determination:

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

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

The Medicare Contractor issued the Provider's Notice of Program Reimbursement on March 27, 2018. The 185th day fell on Friday, September 28th, 2018. The appeal was not filed with the Board until Monday, October 1, 2018. This is 188 days after issuance of the final determination.

In addition, 42 C.F.R § 405.1835(b) specifically requires the Provider to include documentary evidence to demonstrate that the Provider satisfies the hearing request requirements as specified in paragraph (a). The regulation authorizes the Board to dismiss with prejudice any appeal that does not comply.

Because the appeal filed by University of Utah Hospital and Clinics was not timely filed and did not include a copy of the final determination or a calculation of the reimbursement impact, the Board finds that it does not meet the regulatory filing requirements and hereby dismisses Case No. 19-0178.

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

Board Members:
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:

12/18/2018

X Charlotte F. Benson

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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DEC 20 2018

RE: **Expedited Judicial Review Determination**

13-1965GC	Premier Health Partners 2006 DSH Medicare Medicare/Medicaid Part C Days Group
13-2083GC	McLaren Health Care 2007 DSH Medicare/Medicaid Part C Days Group
13-2224GC	Community Health Network 2006 DSH Medicare/Medicaid Part C Days Group
13-3551GC	Trinity Health 2008 DSH Medicare/Medicaid Medicare Advantage Days Group
14-0594GC	Thomas Health System, Inc. 2008 Medicare/Medicaid Fraction Part C Days Group
15-0237GC	McLaren Health Care 2012 DSH Medicare/Medicaid Fraction Part C Days Group
15-2095GC	WakeMed 2011 DSH Medicare/Medicaid Part C Days Group
15-3097GC	Community Healthcare System 2012 DSH Medicare/Medicaid Fraction Part C Days Group
17-1851G	Hall Render 2013 DSH Medicare/Medicaid Part C Days Group III

Dear Ms. Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' November 30, 2018 request for expedited judicial review (EJR) (received December 3, 2018). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

> The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.[1]

[1] Providers' EJR Request at 2.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[6] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[7] The DPP is defined as the sum of two fractions expressed as percentages.[8] Those two fractions are referred to as the "Medicare/SSI"[9] 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 CMS, and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).
[5] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[6] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(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] "SSI" stands for "Supplemental Security Income."
[10] 42 C.F.R. § 412.106(b)(2)-(3).

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

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

Medicare Advantage Program

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

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

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

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

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

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

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

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

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

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

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[13] 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).
[14] *Id.*
[15] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[16] 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).
[17] 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).
[18] 69 Fed. Reg. at 49,099.

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

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

Although the change in policy regarding 42 C.F.R. § 412.106(b)(2)(B) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 final rule was issued.[20] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change announced in the FFY 2005 IPPS final rule. As a result, Part C days were required to be included in the Medicare fraction as of October 1, 2004.

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius,*[21] vacated the FFY 2005 IPPS rule. However, as the Providers point out, the Secretary has not acquiesced or taken action to implement the decision[22] and the decision is not binding in actions by other hospitals.

Providers' Request for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare

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[19] *Id.*
[20] 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).
[21] 746 F. 3d 1102 (D.C. Cir. 2014).
[22] October 23, 2017 EJR Request at 8.

Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. §1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[23]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[24]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[25]

With respect to EJR, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructions it to do so.[26]

Decision of the Board

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's 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.

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[23] *Id.* at 2.
[24] *Id.*
[25] *Id.*
[26] *Id.* at 7

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006-2008 and 2011-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen (Bethesda).*[27] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[28]

On August 21, 2008, new regulations governing the Board were effective.[29] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[30] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[31]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on 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.

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[27] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[28] *Bethesda at 1258-59.*
[29] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[30] 201 F. Supp. 3d 131 (D.D.C. 2016).
[31] *Banner* at 142.

However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that participants involved with the instant EJR request which appeal original Notices of Program Reimbursement are governed by the provisions of *Bethesda* and CMS Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[32] and the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding Its Authority to Consider the Appealed Issue

The Providers within this EJR request filed appeals covering calendar years 2006-2008 and 2011-2013, thus the cost reporting periods fall squarely within the time frame that covers the Secretary's final rule being challenged. In addition, the Board recognizes that the D.C. Circuit vacated the regulation in *Allina* for the time period at issue in these requests. However, the Secretary has not formally acquiesced to that vacatur and, in this regard, has not published any guidance on how the vacatur is being implemented (*e.g.*, only circuit-wide versus nationwide). *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.D. 2016), *appeal filed*, No. 16-5314 (D.C. Cir., Oct 31, 2016). Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located. *See* 42 U.S.C. § 1395oo(f)(1). In addition, within its July 25, 2017 decision in *Allina Health Services v. Price*, the D.C. Circuit Court agreed with the Board's determination to grant EJR for the identical issue involved in the instant EJR request.[33]

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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[32] *See* 42 C.F.R. § 405.1837.

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

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

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

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

Board Members Participating:

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FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

Enclosures: Schedules of Providers

cc: Bryon Lamprecht, WPS (Electronic Mail w/Schedules of Providers)
Judith Cummings, CGS (Electronic Mail w/Schedules of Providers)
Laurie Polston, Palmetto GBA c/o NGS (Electronic Mail w/Schedules of Providers)
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