DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Stephanie A. Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave, N.W.
Washington, D.C. 20006

RE: ***Decision on Jurisdiction and EJR Request***
The Washington Hospital (Prov. No. 39-0042; FYE 6/30/2008)
Case No. 21-0092

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's October 16, 2020 request for hearing and expedited judicial review ("EJR"). The Board's jurisdictional and EJR determinations are set forth below.

Background

On October 16, 2020, the Provider filed its hearing request from a revised Notice of Program Reimbursement ("NPR") dated April 20, 2020. The appeal contains two issues:

(1) [T]he proper treatment of the Medicare disproportionate share ("DSH") calculation of days for patients who where enrolled in Medicare Advantage plans under [P]art C of the Medicare statute ("[P]art C days"). In the 2004, final rule, CMS [Centers for Medicare & Medicaid Services] first announced a policy change to begin counting [P]art C days in the Medicare/SSI fraction and to exclude those days from the numerator of the Medicaid fraction.

(2) The determination of the Provider's [DSH] adjustment payment under the prospective payment system ("PPS") for inpatient hospital services. [W]hether the [CMS] has correctly determined the number of patient days counted in the numerator of the "Medicare Part A/SSI fraction" used in calculating the Provider's disproportionate patient percentage for purposes of the DSH adjustment. The Provider contends that the Medicare Part A/SSI fraction is understated to the extent that CMS has not corrected systemic flaws in the data match process used by CMS in determining the Medicare Part A/SSI fraction.

Issue 1 concerns the treatment of Medicare Advantage days in the calculation of the DSH adjustment. Concurrent with the appeal request (*i.e.*, on October 16, 2020), the Provider filed an EJR request for Issue 1.

The documentation submitted with the Provider's hearing request reveals that, on September 24, 2013, pursuant to 42 C.F.R. § 412.106(b)(3), the Provider requested that the Medicare Contractor reopen the Provider's cost report to recalculate the Provider's SSI/Medicare fraction based on its cost reporting period ending June 30, 2008. On November 5, 2019, the Medicare Contractor issued a Notice of Reopening to perform the following actions relating to the disproportionate share hospital ("DSH") adjustment calculation:

- [U]pdate the SSI percentage and DSH payment percentage based on the Provider's request to base the SSI percentage on [its] cost report Fiscal Year, as calculated and approved by CMS.
- [I]ncorporate settlement (final, tentative, OR HITECH) or lump sum amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
- [A]ddress cost report software updates and edits and correct cost report mathematical and flow errors, as necessary.

The revised NPR implementing the changes above was issued on April 20, 2020. The Provider's October 16, 2020 hearing request indicated that the Provider was appealing the same adjustments for both issues, Adjustments Nos. 4 and 6. Adjustment No. 4 updated the SSI percentage used in the inpatient PPS DSH calculation and recalculated the allowable DSH percentage and Adjustment 6 updated the capital DSH payment.

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), 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 to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018) explains the effect of a cost report revision:

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

In this case, the Provider appealed a revised NPR that did not adjust Issue 1 (the Part C issue) or Issue 2 (the systemic flaws in the SSI data match issue) as required for Board jurisdiction, rather it was an appeal of a revised NPR issued to implement the Provider's request for an SSI realignment under 42 C.F.R. § 412.106(b)(3).

The regulation, 42 C.F.R. § 412.106(b)(3), permits a provider to request to have its data reported on its cost reporting period instead of the Federal fiscal year. To do so, "It must furnish to CMS, through its Intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period."

The Washington Hospital requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. The Notice of Reopening clearly states that the purposes of the reopening was to "update the SSI percentage and DSH payment percentage based on the Provider's request to base the SSI percentage on [its] cost report Fiscal Year, as calculated and approved by CMS." To this end, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. When CMS performs the realignment process, it does not utilize a new or different data match process when it issues a

realigned SSI percentage and, in particular, does not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[1] Rather, it is simply that a different 12-month time period is used. Since the revised NPR for The Washington Hospital (Prov. No. 39-0042, FYE 6/30/2008) did not adjust the Part C days issue or the data match issue as required by 42 C.F.R. § 405.1889, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal the revised NPR for both issues and that, as a result, the Board lacks jurisdiction over both issues in the appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[2] Accordingly, the Board hereby, dismisses the case and, since 42 C.F.R. § 405.1842(f) specifies that jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board also denies the Provider's request for EJR of the Part C Days issue.

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

Board Members Participating:

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

For the Board:

11/6/2020

X Clayton J. Nix

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Wilson Leong, FSS

[1] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[2] *See, e.g., St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Johnston Memorial Hospital (49-0053)
FYE: 6/30/2009
PRRB Case: 13-3345

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 DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On September 6, 2013, the Board received the Provider's Individual Appeal Request, appealing their March 13, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2009. The initial appeal contained the following seven (7) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – Medicare Managed Care Part C Days
5. DSH Payment – Medicaid Eligible Labor Room Days
6. DSH Payment – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
7. Outlier Payments – Fixed Loss Threshold

On April 2, 2014, Issues 2, 4, 6, and 7 were transferred to group appeals. Issue 5 was withdrawn in the Provider's Preliminary Position Paper, and Issue 3 was withdrawn by the Provider on September 22, 2020. The only remaining issue is Issue 1 - DSH/SSI Percentage (Provider Specific).

The Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .

> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

The Provider described its DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 14-3113GC, as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, the Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible Days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days
6. Non-covered days, *i.e*. Exhausted benefit, Medicare Secondary Payor Days and Medicare Advantage, Medicare Managed Care, Medicare+Choice and/or Part C Days
7. CME Ruling 1498-R, and
8. Failure to adhere to required notice and comment rulemaking procedures.[2]

On October 22, 2020, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is duplicative of the issue which was transferred to Case Number14-3313GC. It also argues that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature, since there was no final determination.[3]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Provider's individual appeal is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. This is duplicative of the SSI Systemic Errors issue that was directly added to Common Issue Related Party ("CIRP") group, Case Number 14-3113GC: "Whether the Secretary properly calculated the Providers DSH/SSI Percentage." [4] The Providers in the CIRP group challenge

[1] Individual Appeal Request at Tab 3.
[2] *Id.*
[3] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Oct. 22, 2020).
[4] *See* CIRP Group Issue Statement, case number 16-2359GC.

their SSI percentages because of a disagreement over how the SSI percentage is calculated, and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation. Pursuant to PRRB Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider Specific issue is duplicative of the issue the Provider is appealing in the group appeal, and dismisses the SSI Provider Specific issue.

In its SSI Provider Specific issue statement, the Provider asserted that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "if a hospital prefers that CMS use its cost reporting data instead of the Federal Fiscal Year, it must furnish to CMS, through its intermediary, a written request…" Indeed, without the Medicare Contractor rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3) In fact, the Medicare Contractor points out that: the Provider requested an SSI realignment on May 26, 2020; the request was forwarded to CMS on June 11, 2020; a Notice of Cost Report Realignment agreeing to revise the cost report based on the realigned SSI percentage was sent to the Provider on August 6, 2020; however, to date, CMS has not advised the Medicare Contractor on the realigned SSI percentage.[5] Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue statement.

Conclusion:

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue and hereby dismisses the issue from this appeal. As no issues remain pending, PRRB Case No. 13-3345 is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/10/2020

X Susan A. Turner

Susan A. Turner, Esq.
Board Member
Signed by: Susan A. Turner -S

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services

[5] *Id.* (citing Exhibits C-3 through C-5).

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

RE: ***Jurisdictional Decision***
Johnston Memorial Hospital (49-0053)
FYE: 6/30/2009
PRRB Case No.: 14-1616

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 DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On January 3, 2014, the Board received the Provider's Individual Appeal Request appealing their July 3, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending June 30, 2010. The initial appeal contained the following nine (9) issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
6. DSH Payment – Medicaid Eligible Labor Room Days
7. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
8. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)
9. Outlier Payments – Fixed Loss Threshold

On August 14, 2014, Issues 2, 4, 5, 7, 8, and 9 were transferred to group appeals. Issue 6 was withdrawn in the Provider's Preliminary Position Paper, and Issue 3 was withdrawn by the Provider on September 22, 2020. The only remaining issue is Issue 1 - DSH/SSI Percentage (Provider Specific).

The Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[1]

The Provider described its DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 14-3952GC, as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, the Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs. Eligible Days,
3. Not in agreement with provider's records,
4. Fundamental problems in the SSI percentage calculation,
5. Covered days vs. Total days
6. Failure to adhere to required notice and comment rulemaking procedures.[2]

On October 22, 2020, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is duplicative of the issue which was transferred to Case Number14-3952GC. It also argues that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and since the Provider did not request an SSI realignment, appealing this issue is premature since there was no final determination.[3]

Board Decision:

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

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to

[1] Individual Appeal Request at Tab 3.
[2] *Id.*
[3] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Oct. 22, 2020).

determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was transferred to Case Number 14-3952GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[4] The Provider's legal basis for its DSH/SSI - Provider Specific issue is that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[5] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[6]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 14-3952GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 17-1532GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

The second aspect of the DSH SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for a lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), when determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied, for appeal purposes.

Conclusion:

The Board finds that it does not have jurisdiction over the last remaining issue in the appeal, the SSI Provider Specific issue. As no issues remain pending, Case No. 14-1616 is closed and removed from the Board's docket.

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

[4] Model Form A – Individual Appeal Request, Tab 3 at 2 (Jan. 22, 2019).
[5] *Id.*
[6] *Id.*

Board Members Participating:

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

For the Board:

11/10/2020

X Susan A. Turner

Susan A. Turner, Esq.
Board Member
Signed by: Susan A. Turner -S

cc: Wilson C. Leong, Esq., Federal Specialized Services
Laurie Polson, Palmetto GBA c/o National Government Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

Jason Williams
Henry Ford Health System
1 Ford Place – 5F
Detroit, MI 48202

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

RE: ***Jurisdictional Decision in Whole***
Henry Ford Wyandotte Hospital (Prov. No. 23-0146)
FYE 12/31/2006
Case No. 13-2592

Dear Messrs. Williams and Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's ("MAC") Jurisdictional Challenge of Henry Ford Wyandotte Hospital's ("Provider") Part C Days issues in its individual appeal from its Revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Board received the Provider's Request for Hearing dated August 5, 2013, related to a revised NPR dated February 11, 2013.[1] The provider's appeal request contained the following summarized issue statement:

> Issue: Medicare Advantage Days
>
> The issue in this appeal concerns the treatment in the calculation of the Medicare disproportionate share hospital ("DSH") payment of inpatient days for Medicaid-eligible patients who were enrolled in a Medicare Advantage plan under part C of the Medicare statute. These days were excluded from the numerator of the Medicaid fraction that is used to calculate the DSH payment for the cost reporting periods at issue. CMS's alleged policy change first announced in August 2004 to begin counting Medicare part C days in the Medicare Part A/SSI fraction and to exclude those days from the numerator of the Medicaid fraction (for patients also eligible

[1] Provider's Request for Appeal (Aug. 5, 2013), PRRB Case No. 13-2592.

> for Medicaid) is invalid on its face and as applied in calculating the Provider's DSH payment for the period at issue here…. The Provider contends that all of the Medicaid eligible Medicare part C days at issue *must be counted in the numerator of the Medicaid fraction* and that part C days must be excluded in their entirety from the Medicare Part A/SSI fraction.[2]

The Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge on July 23, 2014, stating that the Board does not have jurisdiction over the Medicare Advantage days – Medicaid Fraction in the above referenced case because the MAC did not make an adjustment related to the days in question. The MAC requests that the Board dismiss the issue.

Medicare Contractor's Jurisdictional Challenge

The MAC asserts that it did not make an adjustment to Medicaid days on the revised cost report.[3]

The Notice of Reopening was issued "to revise the Medicare SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS."[4]

According to the MAC, the Notice of Correction of Program Reimbursement did not adjust the Medicaid fraction portion of the disproportionate share payment. In accordance with 42 C.F.R. § 405.1835(a):

> A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination . . .

The audit adjustment report did not impact the Medicaid fraction of the disproportionate share payment but did impact the SSI percentage. Therefore, the MAC argues that this appeal for Medicare Advantage days should be limited to the impact on the SSI percentage.[5]

The MAC concludes that it has not made a determination with respect to the provider for the issues appealed. The MAC believes the appeal for Medicare Advantage days should be limited to the SSI portion of the issue.[6]

[2] *Id.* at Tab 3 (Issue Statement) (emphasis added).
[3] MAC's Jurisdictional Challenge, at 1 (Jul. 23, 2014).
[4] *Id*.
[5] *Id*.
[6] *Id*.

Board's Analysis and Decision

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

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2013) provides in relevant part:

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

42 C.F.R. § 405.1889 (2013) explains the effect of a cost report revision:

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

The Board finds that it has jurisdiction over the Provider's appeal from its revised NPR for the Part C Days issue in both the SSI/Medicare and Medicaid Fractions.

The Provider's revised NPR was issued as the result of a reopening:

> To revise the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data

submitted by providers, which will be included in revised SSI ratios to be published by CMS.

As the MAC noted, the adjustment report and workpaper only included adjustments to the SSI percentage for "Medicare Advantage data" and per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[7] Thus, pursuant to *Allina*, if the provider were to be successful in its regulatory challenge, then the Part C days would have to be moved from the SSI fraction to the Medicaid fraction. Accordingly, the Board thus finds that it has jurisdiction over the complete Part C days issue.

Case No. 13-2592 remains open with the Part C Days in the Medicare and Medicaid fractions issue remaining, which will be remanded under separate cover pursuant to CMS Ruling 1739-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 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

11/17/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Plano, TX 75093-8724

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

RE: ***Jurisdictional Decision***
Southwest Consulting CY 2007 -2010 DSH Post 1498R Medicare Part A/SSI% Group
Case No. 20-1236G

Dear Mr. Newell and Mr. Snyder,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned optional group appeal which was recently expanded to include additional calendar years ("CY's"). The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Background

On February 20, 2020, Southwest Consulting Associates ("SCA"/"Representative") filed the subject group appeal. The group issue statement indicates the group is appealing:

> whether the Centers for Medicare & Medicaid Services ("CMS") has correctly determined the SSI fraction" used in calculating the Provider's disproportionate patient percentage for purposes of the DSH adjustment. The Provider contend that the SSI Fraction is understated to the extent that CMS has not corrected systemic flaws in the data and match process used by CMS in determining the SSI fractions. ("SSI – *Baystate* Errors")[1]

There are currently seven participants in this group appeal, six of which appealed from Revised Notices of Program Reimbursement ("RNPRs") as follows:

Participant 1: Christ Hospital (36-0163) 6/30/2007
Directly Added to Group on 2/20/2020

- Reopening Request dated February 2, 2015
  - Reopening included the following language: The Provider ". . .requests a realignment of the Federal Fiscal Year (FFY) 2006 SSI ratio to the Hospital's Fiscal Year of July 1, 2006 through June 30, 2007."

[1] Statement of Issue uploaded in the Office of Hearings Case & Document Management System ("OH CDMS") (Feb. 20, 2020).

- Notice of Intent to Reopen dated February 11, 2015
    - The Reopening was issued "To use the hospital's fiscal year end 6/30/2007, to calculate the SSI percentage instead of the federal fiscal year end."
- Revised NPR dated September 4, 2019
- Audit Adjustments 1, 3: Both were made to update the SSI % in accordance with CMS' SSI realignment calculation.

Participant 2: Sharon Regional Health System (39-0211) FYE 6/30/2010
Transferred to Group on 3/16/2020 from Case 19-2613

- Reopening Request dated July 21, 2015
    - Reopening included the following language: The Provider ". . . requests that the Medicare SSI ratio for this period be computed on the Hospital fiscal year (7/1/2009 to 6/30/2010) basis instead of the Federal fiscal year (10/1/2008 to 9/30/2009) basis for the cost report ending 6/30/2010."
- Notice of Reopening dated January 26, 2018
    - The Reopening was issued "To review your request to recalculate the hospital's Acute SSI percentage based on the hospital's fiscal year end 6/30/2010."
- Revised NPR dated March 15, 2019
- Audit Adjustment 5: To adjust allowable DSH percentage to account for CMS' recalculation of the Provider's SSI %.

Participant 4: University of Cincinnati Medical Center, LLC (36-0003) FYE 6/30/2009
Directly Added to Group on 3/26/2020

- No Reopening Request submitted (although Reopening refers to Provider's June 17, 2015 request).
- Notice of Intent to Reopen dated June 22, 2015
    - The Reopening was issued "To updated the SSI% based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received June 17, 2015."
- Revised NPR dated October 2, 2019
- Audit Adjustments 1, 3: Both were made to update the SSI % in accordance with CMS' SSI realignment calculation.

Participant 5: Christ Hospital (36-0163) FYE 6/30/2010
Directly Added to Group on 5/14/2020

- Reopening Request dated February 2, 2015
    - Reopening included the following language: The Provider ". . .requests a realignment of the Federal Fiscal Year (FFY) 2009 SSI ratio to the Hospital's Fiscal Year of July 1, 2009 through June 30, 2010."

- Notice of Intent to Reopen dated February 11, 2015
    - The Reopening was issued "To use the hospital's fiscal year end 6/30/2010, to calculate the SSI percentage instead of the federal fiscal year end."
- Revised NPR dated December 19, 2019
- Audit Adjustments 1, 3: Both were made to update the SSI % in accordance with CMS' SSI realignment calculation.

Participant 6: Sharon Regional Health System (39-0211) FYE 6/30/2007
Directly Added to Group on 8/5/2020

- Reopening Request dated July 21, 2015
    - Reopening included the following language: The Provider ". . . requests that the Medicare SSI ratio for this period be computed on the Hospital fiscal year (7/1/2009 to 6/30/2010) basis instead of the Federal fiscal year (07/31/2006 to 6/30/2007) basis for the cost report ending 6/30/2007."
- Notice of Reopening dated September 27, 2019
    - The Reopening was issued "To update the SSI percentage and DSH payment percentage based on the Provider's request to base the SSI percentage on their cost report Fiscal Year, as calculated and approved by CMS."
- Revised NPR dated February 11, 2020
- Audit Adjustment 5: To update the SSI percentage and recalculate the allowable DSH.

Participant 7: Christ Hospital (36-0163) FYE 6/30/2008
Transferred to Group from Case 20-1475 on 10/26/2020

- Reopening Request dated February 2, 2015
    - Reopening included the following language: The Provider ". . .requests a realignment of the Federal Fiscal Year (FFY) 2007 SSI ratio to the Hospital's Fiscal Year of July 1, 2007 through June 30, 2008."
- Notice of Intent to Reopen dated February 11, 2015
    - The Reopening was issued "To use the hospital's fiscal year end 6/30/2008, to calculate the SSI percentage instead of the federal fiscal year end."
- Revised NPR dated October 2, 2019
- Audit Adjustments 1, 3: Both were made to update the SSI % and payment factor in accordance with CMS' SSI realignment calculation.

The only participant in the group that appealed from an original NPR is **the University of Colorado Hospital Authority (06-0024) for FYE 6/30/2009 (Participant 3)**. This participant transferred into the group from an individual appeal (Case No. 14-0805), which was subsequently closed on March 18, 2020.

Board Decision

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2018)[2] explains the effect of a cost report revision:

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the six Providers that appealed from RNPRs in this appeal because the RNPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the SSI *Baystate* issue, which is the issue under appeal in this group.

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[2] *See also St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] The reopenings in this case were a result of the Providers' requests to realign their SSI percentages from the Federal Fiscal Year End to their individual cost reporting fiscal year ends. The audit adjustments associated with the RNPRs under appeal clearly only revised the SSI percentages in order to realign it from a federal fiscal year to the providers' respective fiscal years and did not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to days or other aspects of the monthly data since the underlying monthly data remains the same).[4] The Notices of Reopening explicitly stated that the purpose of each reopening was issued to use the hospital's fiscal year end to calculate the SSI percentage instead of the federal fiscal year end. In other words, the determinations were only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPRs were adjustments related to realigning the SSI percentage from the federal fiscal year to the provider fiscal year, the Board does not have jurisdiction over the following participants (which each appealed from an RNPR) pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b):

Ptcp #	**Provider Name/No.**	**CY**	**Source**
1	Christ Hospital (36-0163)	2007	Direct Add
2	Sharon Regional Health System (39-0211)	2010	Transf. From 19-2613
4	University of Cincinnati Medical Center (36-0003)	2009	Direct Add
5	Christ Hospital (36-0163)	2010	Direct Add
6	Sharon Regional Health System (39-0211)	2007	Direct Add
7	Christ Hospital (36-0163)	2008	Transf. From 20-1475

The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5]

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[3] 42 C.F.R. § 405.1889(b)(1).

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

[5] *See, e.g., St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

In conclusion, these six participants are dismissed from the appeal because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), these participants do not have the right to appeal the RNPRs at issue. 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.

After the dismissal of the six participants, University of Colorado Hospital Authority (06-0024) is the ***sole*** participant remaining in the optional group for CY 2009. While this optional group is not fully formed/complete, Board Rule 12.6.2 specifies that "[o]ptional groups must have a minimum of two different providers, both at inception and at full formation of the group." As the optional group no longer meets the minimum number of participants, the Board must make a determination on how to dispose of the University of Colorado Hospital Authority, (*e.g.*, whether to reinstate and transfer the Provider back to its prior individual case or transfer the Provider to another optional group).

Prior to the Board making this determination, the Board reviewed its docket and has identified that there is another pending optional group for the Southwest Consulting 2007, 2009 DSH Post 1498R Medicare Part A/SSI % under Case No. 16-0754G. The group, which includes CY's 2007 and 2009, was fully formed on January 28, 2017. Ropes & Gray, LLP is currently the authorized representative for Case No. 16-0754G, which is scheduled for a concurrent hearing with a number of other DSH Post 1498R Medicare Part A/SSI % groups in June 2021.

Board Rule 18 states that: "After opportunity for comment by the parties, the Board may require a group to restructure appeals either to comply with the law or for judicial economy." With respect to Case No. 20-1236G, the Board intends to exercise its discretion under Board Rule 18 for purposes of judicial economy to reopen Case No. 16-0754G and to transfer University of Colorado Hospital Authority (06-0024) to Case No. 16-0754G. Following that transfer, the Board would close Case No. 20-1236 and re-designate Case No. 16-0754G as fully formed.

Accordingly, the Board requests comments from SCA regarding which of the following actions it would prefer the Board to take:

1. Reinstate the Provider's individual case (Case No. 14-0805) and transfer back the SSI *Baystate* issue for University of Colorado Hospital Authority;

2. Reopen the status of Case No. 16-0754G to allow University of Colorado Hospital Authority to be transferred into it for purposes of judicial efficiency consistent with Board Rule 18;

3. Transfer in another provider with the same common issue and year to Case No. 20-1236G; or

4. Transfer the Provider to another optional group having the same common issue and year.

The letter serves as notice to the Parties that the Board intends to take one of the above-listed actions and that the Parties have ***fifteen (15) days from this letter's signature date*** to comment on which action they prefer as well as whether they are in agreement with the intended action, in whole or in part. *Be advised that* ***this filing deadline is firm*** *as the Board has determined to specifically exempt it from Board Alert 19's suspension of Board filing deadlines. As a result, failure of either Party to respond by the above filing deadline will result in the Board ruling on its intended actions without the benefit of that Party's input.*

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/18/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Stephanie Webster, Ropes & Gray, LLP
Justin Lattimore, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Geoffrey Pike
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RE: ***Jurisdictional Decision***
Larkin Community Hospital (Prov. No. 10-0181)
FYE 12/31/2006
Case No. 13-1604

Dear Messrs. Ravindran and Pike,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed jurisdiction in the above-referenced individual appeal filed by Larkin Community Hospital ("Provider"). The Board's decision is set forth below.

Background

On April 11, 2013, Larkin Community Hospital filed its appeal of the Revised Notice of Program Reimbursement ("RNPR") dated October 12, 2012 for its fiscal year ending December 31, 2006 ("FY 2006"). The appeal request contained the following issues:

1) DSH – SSI% Provider Specific;
2) DSH – SSI% Systemic;
3) Rural Floor Budget Neutrality Adjustment.[1]

Issue 2 contained multiple components and, on November 21, 2013, the Provider transferred them as follows: SSI% Systemic Errors to Case No. 13-1439G, and all "non-covered days" issues (including Exhausted, and Dual Eligible days) to other groups. Accordingly, there are only two issues remaining in this appeal — Issues 1 and 3.[2]

On April 19, 2013, the Board requested additional information from the Provider regarding its initial appeal, including Audit Adjustment pages, Reopening Notices, and other applicable documentation, which the Provider provided to the Board on June 7, 2013. In its Notice of Reopening, the MAC noted that the cost report was opened to:

[1] Provider's Request for Hearing, Issue Statement at Tab 3 (Apr. 11, 2013).
[2] Request to Transfer Issues (Nov. 21, 2013).

> To receive the Medicare-SSI fraction in the DSH calculation to ensure the accurate inclusion of Medicare Advantage data submitted by providers, which will be included in revised SSI ratios to be published by CMS.[3]

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over either Issue No. 1 regarding DSH/SSI Percentage (Provider Specific) issue, ***or*** Issue No. 2, the Rural Floor Budget Neutrality Adjustment issue.

SSI Provider Specific

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue in this case. The jurisdictional analysis has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of the SSI Provider Specific issue – the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage – is duplicative of the Systematic Errors issue.[4] The DSH Payment/SSI Percentage (Provider Specific) issue concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportional Share Hospital Calculation."[5] The Provider's legal basis for the issue also asserts that the "Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[6] The Provider argues that "its SSI percentage published by [CMS] was incorrectly computed . . . ." and, to the end, "[t]he Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[7]

However, the Provider's Systemic Errors issue is "[whether] the Secretary properly calculated the Provider's Disproportional Share Hospital/Supplemental Security Income percentage".[8] The Provider's legal basis for the Systemic Errors issue addresses how the SSI percentage has been improperly calculated due to, among other things:

1. The lack of availability of MedPAR and SSA records—"This data is a key component in determining whether affected hospitals may be entitled to increased reimbursement . . . .

[3] Notice of Reopening, at 1 (Jun. 7, 2013).
[4] Provider's Request for Hearing, Issue Statement at Tab 3.
[5] *Id.* At Tab 3, Issue 1.
[6] *Id.*
[7] *Id.*
[8] *Id.* At Tab 3, Issue 2.

However, the regulations impost restrictive conditions that do not permit the Provider to obtain and reconcile the SSI data maintained by the Social Security Administration."
2. Fundamental problems in the SSI percentage calculation as outlined in the *Bastate* litigation
3. Continued deficiencies in the matching methodology under CMS Ruling 1498-R

Thus, the Provider's disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systematic Errors issue that was transferred to a group appeal as noted above. Because the Systematic Errors issue is pending in a group appeal, the Board dismisses this aspect of the SSI Provider Specific Issue.

The second aspect of this issue – the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period – is dismissed for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. Furthermore, even if a Provider had requested a realignment from the Federal Fiscal Year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.[9]

Rural Floor Budget Neutrality Adjustment (RFBNA) Issue

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2012) provides in relevant part:

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

[9] *See* 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)). *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.).

42 C.F.R. § 405.1889 (2012) explains the effect of a cost report revision:

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

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> If a final contractor determination is reopened under §405.1885, any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination (§§405.1887(d), 405.1889(b), and the "Exception" in §405.1873(c)(2)(i)).

The Board finds that it does not have jurisdiction over the RFBNA issue, as the issue was not adjusted in the Provider's RNPR. The above regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. Here, the RNPR dated October 12, 2012, included a total of eight adjustments and the adjustments related directly to the incorporation of a revised SSI percentage.[10] As the RFBNA was not part of the reopening appealed, the Board lacks jurisdiction over RFBNA issue because, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal the RNPR for the RFBNA issue. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[11]

Conclusion

The Board dismisses both the SSI Provider Specific issue and the RFBNA issue. As there are no remaining issues, Case No. 13-1604 is closed and removed from the Board's docket.

[10] Audit Adjustment Report (Jun. 7, 2013).
[11] *See, e.g., St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/18/2020

X Clayton J. Nix

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cc: Wilson Leong, Federal Specialized Services

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RE: ***Jurisdictional Decision***
14-2965GC SRI Presence Health 2009 SSI Realignment CIRP Group
14-3021GC SRI Presence FY 2007 SSI Realignment CIRP
14-3337GC SRI Presence Health 2008 SSI Realignment Group
14-3352G SRI 2008 SSI Realignment Group
14-3865G SRI 2009 SSI Realignment Group
15-0413GC SRI Aurora 2006-2008, 2010, 2011 SSI Realignment CIRP

Dear Mr. Putnam and Ms. Harley,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above-referenced six group appeals on its own motion. The Board's decision is set forth below.

Background

Strategic Reimbursement Group, LLC has filed numerous group appeals relating to SSI Realignment. Many of these groups have a related appeal of the SSI Accuracy Ratio issue for the same Providers and fiscal year ends ("FYEs"). There are six (6) Group Appeals for the SSI Realignment issue, which are the subject of the Board's decision.

All six group cases were filed with a matching SSI Accuracy appeal that was filed at the same time as the SSI Realignment appeals:

14-2965GC	**SRI Presence Health 2009 SSI Realignment CIRP Group**
14-2964GC	SRI Presence Health 2009 SSI Calculation Error CIRP Group
14-3021GC	**SRI Presence FY 2007 SSI Realignment CIRP**
14-1402GC	SRI Presence Health 2007 SSI Calculation Error CIRP Group
14-3337GC	**SRI Presence Health 2008 SSI Realignment Group**
14-2833GC	SRI Presence Health 2008 SSI Calculation Error CIRP Group
14-3352G	**SRI 2008 SSI Realignment Group**
14-1573G	SRI FY 2008 SSI Calculation Error Group

14-3865G	**SRI 2009 SSI Realignment Group**
14-3329G	SRI 2009 SSI Calculation Error Group

15-0413GC	**SRI Aurora 2006-2008, 2010, 2011 SSI Realignment CIRP**
14-1970GC; 14-1577GC; 14-3572GC; 15-0255GC; & 15-0244GC	SRI Aurora 2006-2008, 2010, 2011 SSI Calculation Error CIRP groups

The Providers used the same issue statements for the SSI Realignment appeals, and the same issue statements for the SSI accuracy appeals.

SSI Realignment Appeals:

> The Provider challenges the sample period used to determine the hospital's SSI ratio. The current calculation is based on a sample period covering the Federal Fiscal Year rather than a period covering the hospital's Fiscal Year.
>
> The Provider request that the sample period used to determine the hospital's SSI ratio be revised to match the hospital's Fiscal Year in accordance with 42 CFR Subpart G Section 412.106, 42 CFR Subpart M Section 412.320, and 42 CFR Subpart P Section 412.624.

SSI Accuracy Appeals:

> The Provider challenges the Supplemental Security Income (SSI) ratio used in the Intermediary's adjustments relating to the Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations"). It is the provider's position that the methodologies and practices applied by CMS' in the determination of the SSI ratios are flawed, including, but not limited to, the method CMS' implements to match hospital's patients to Federal SSI databases. The provider contends that the SSI ratio as generated by the SSA and put forth by CMS is understated.
>
> The provider requests that CMS provide all underlying information used to calculate the provider's SSI ratio and allow the provider review, test, and submit a corrected SSI ratio for purposes of

revising the Calculations in accordance with 42 CFR Subpart G Section 412.106, 42 CFR Subpart M Section 412.320, and 42 CFR Subpart P Section 412.624.

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more (or $50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the SSI Realignment issue in Case Nos. 14-2965GC, 14-3021GC, 14-3337GC, 14-3352G, 14-3865G, and 15-0413GC because there is no final determination(s) from which the Providers are appealing this issue. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period (fiscal year end) data instead of the federal fiscal year end data in determining the DSH Medicare fraction. The decision to use its own cost-reporting period is the hospitals alone and, to initiate this process, the hospital must submit a written request to the Medicare Contractor. Without these requests, it is not possible for the Medicare Contractor to have issue a final determination from which any of the Providers could appeal. Furthermore, even if a Provider had requested a realignment from the Federal Fiscal Year to its cost reporting year, 42 C.F.R. § 412.106(b)(3) makes clear that the Provider must use the data from its cost reporting year; there is no appeal right that stems from a realignment request.[1]

Additionally, the Board finds that the SSI Realignment is duplicative, in part, of the SSI Accuracy Group appeal.[2] This violates Board Rules, which provide, "A Provider may not appeal an issue from a final determination in more than one appeal."[3] Therefore, having two group appeals that make the same argument related to the SSI ratio is duplicative in violation of Board Rule 4.5 (Mar. 1, 2013 and July 1, 2015). The Provider is ultimately seeking the same remedy

[1] *See* 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital **must accept** the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)). *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.).

[2] For example, the main thrust of the SSI Realignment appeals is the alleged lack of access to data and this a tenant of the SSI Accuracy appeals.

[3] PRRB Rule 4.5 (March 1, 2013 and July 1, 2015 Versions).

from the two types of appeals – they want access to the underlying data so that they can determine that their ratios are understated and can therefore receive a new SSI ratio.

Conclusion

The Board finds that it does not have jurisdiction over the group issue in the SSI Realignment Groups because there is not final determination from which the Providers can appeal. The Board also finds the issue is duplicative, in part, of those issues in the SSI Accuracy group appeals and dependent on the SSI Accuracy group appeals in order to pursue the remedy of a new SSI percentage. Accordingly, the Board hereby dismisses Case Nos. 14-2965GC, 14-3021GC, 14-3337GC, 14-3352G, 14-3865G, and 15-0413GC and removed them from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/18/2020

X Clayton J. Nix

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

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

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November 18, 2020

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Danene Hartley
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RE: EJR Denied (EJR Previously Granted)
SRG 2011 DPP Medicare Part C Days Group
PRRB Case Number: 16-2304G

Dear Mr. Putnam and Ms. Hartley:

On December 12, 2019, the Board requested comments for an Own Motion Expedited Judicial Review ("EJR") for the issue of Part C Days in the Medicare and Medicaid Fractions for the above-captioned optional group appeal. On May 28, 2020, the Board issued an EJR determination, granting EJR, and closing this group appeal. Five and a half months later, on November 13, 2020, the Providers' representative then filed an EJR request for this group appeal. This request is clearly null and void and the case remains closed because: (1) the Board previously granted EJR and closed this case; and (2) the Representative is not asking the Board reopen and reconsider or revise the previously granted EJR. Finally, the Board ADMONISHES the Representative for submitting an EJR request it should have known was erroneous, invalid or void since the Board has already granted EJR and this case is closed. Accordingly, the Board reminds the Representative it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings. The Board may consider taking remedial action with the Representative if a trend in these types of erroneous filings from the Representative develops, including but not limited to carbon copying the underlying provider.

Board Members Participating:
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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services

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Dylan Chinea
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
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Danene Hartley
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Indianapolis, IN 46206

RE: ***Jurisdictional Determination***
Essentia Health 2009 Inclusion of Medicare Part C Days in SSI Ratio Issued 3/16/12 CIRP Grp
Case No. 16-2369GC

Dear Mr. Chinea and Ms. Hartley:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal year ending ("FYE") 2009. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the June 8, 2008 decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") issue and dismisses the instant appeal.

Pertinent Facts

The Providers in the above case filed appeals with the Provider Reimbursement Review Board ("PRRB" or "Board") seeking review of the following IRF-LIP issue:

> *Whether CMS' inclusion of Medicare Dual Eligible Part C Days in the SSI Ratio issued on March 16, 2012 was proper?*[2]
>
> Each group participant disputes the SSI percentage developed by CMS and utilized by the MAC in their updated calculation of Medicare Rehabilitation Facility Low Income Patients payment (LIP), and contends CMS' new interpretation of including Medicare Part C Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision.[3]

[1] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[2] Group Appeal Request, at Tab 2 (Issue Statement) (Sep. 6, 2016).
[3] *Id*.

Board's Analysis and Decision

Set forth below is the Board's decision to dismiss this case consistent with the D.C. Circuit's decision in *Mercy*.

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination.

Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[4]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[5] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the U.S. 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.[6] The D.C. Circuit concluded that the

[4] *Id*.
[5] *Id.* at 1064.
[6] *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).

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.[7]

In the instant appeal, 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 Providers' appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenge this adjustment. In making this finding, the Board notes that its decision is consistent with *Mercy* and that the *Mercy* decision is controlling precedent because the Providers could bring suit in the D.C. Circuit.[8] As this is a group case and includes only this issue, the Board hereby closes the case and remove it from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/18/2020

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

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

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

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RE: Denial of EJR/EJR previously granted
SRG 2009 DPP Medicare Part C Days Group
PRRB Case Number: 16-2590G

Dear Mr. Putnam and Ms. Hartley:

On December 12, 2019, the Board requested comments for an Own Motion Expedited Judicial Review ("EJR") for the issue of Part C Days in the Medicare and Medicaid Fractions in the above-captioned optional group appeal. On May 28, 2020, the Board issued an EJR determination, granting EJR, and closing this group appeal. Five and a half months later, on November 13, 2020, the Providers' representative then filed an EJR request for this group appeal. This request is clearly null and void and the case remains closed because: (1) the Board previously granted EJR and closed this case; and (2) the Representative is not asking the Board reopen and reconsider or revise the previously granted EJR. Finally, the Board ADMONISHES the Representative for submitting an EJR request it should have known was erroneous, invalid or void since the Board has already granted EJR and this case is closed. Accordingly, the Board reminds the Representative it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings. The Board may consider taking remedial action with the Representative if a trend in these types of erroneous filings from the Representative develops, including but not limited to carbon copying the underlying provider.

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Chair

cc: Wilson C. Leong, Federal Specialized Services

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RE: EJR Denied (EJR Previously Granted)
SRG 2010 DSH Medicare Part C Days Group II
PRRB Case Number: 17-1072G

Dear Mr. Putnam and Ms. Hartley:

On December 12, 2019, the Board requested comments for an Own Motion Expedited Judicial Review ("EJR") for the issue of Part C Days in the Medicare and Medicaid Fractions for the above-captioned optional group appeal. On May 28, 2020, the Board issued an EJR determination, granting EJR, and closing this group appeal. Five and a half months later, on November 13, 2020, the Providers' representative then filed an EJR request for this group appeal. This request is clearly null and void and the case remains closed because: (1) the Board previously granted EJR and closed this case; and (2) the Representative is not asking the Board reopen and reconsider or revise the previously-granted EJR. Finally, the Board ADMONISHES the Representative for submitting an EJR request it should have known was erroneous, invalid or void since the Board has already granted EJR and this case is closed. Accordingly, the Board reminds the Representative it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings. The Board may consider taking remedial action with the Representative if a trend in these types of erroneous filings from the Representative develops, including but not limited to carbon copying the underlying provider.

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
BJC Healthcare CY 2016 Two Midnight Census IPPS Payment Reduction CIRP Group
PRRB Case: 19-0742GC

Dear Mr. Kramer,

The above referenced appeal generally challenges the "2 Midnight Rule" set forth in the FY 2014 IPPS Final Rule, which imposed a .2 percent decrease in the IPPS rates for FYs 2014 through 2018. The group was created on January 23, 2019 with one provider, and three additional providers were added on August 14, 2019. On January 13, 2020, the Providers' representative advised that four additional providers were awaiting their final determinations and that the group was not yet fully formed.

On October 13, 2020, a CIRP Group Status Request was issued requiring the representative to advise the Board, no later than November 12, 2020, whether the group was fully formed and, if not, to identify which providers have not yet received a final determination. The request specifically stated that "[f]ailure to submit a timely response to this request will result in dismissal of the case." As of the date of this letter, no response has been submitted by the Providers' representative.

The regulation at 42 C.F.R. § 405.1837(e) states that the Board will determine that a group appeal is fully formed upon a notice in writing from the group that it is fully formed. Absent such a notice, the Board may issue an order requiring the group to demonstrate that at least one provider has preserved the issue for appeal, but has not yet received its final determination with respect to the item for a cost year that is within the same calendar year as that covered by the group appeal (or that it has received its final determination with respect to the item for that period, and is still within the time to request a hearing on the issue).

Pursuant to 42 C.F.R. § 405.1868:

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the board may –
>
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.[1]

[1] *See also* Board Rules 4.1 & 41.2

Having issued a request for the Providers' representative to advise the Board whether the group was fully formed and receiving no response, the Board hereby dismisses this case and will remove it from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/19/2020

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

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Steven Hernandez
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Tenet Healthcare Corporation
14201 Dallas Pkwy
Dallas, TX 75254

RE: ***Jurisdictional Determination***
A. Weiss Memorial Hospital (Prov. No. 14-0082)
FYE 05/31/2007
Case No. 13-1977

Dear Ms. Hartley and Mr. Hernandez:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's ("MAC") Jurisdictional Challenge of two issues in Louse A. Weiss Memorial Hospital's ("Provider") individual appeal from its Revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

BACKGROUND:

The Board received the Provider's Request for Hearing dated April 23, 2013, related to a revised NPR dated November 12, 2012.[1] The provider's appeal request contained the following three aspects of the Disproportionate Share Hospital ("DSH") payment calculation as the cost issues under appeal:

1) *Issue No. 1: SSI Days* – the Provider claims Medicare Advantage Days ("Part C Days") were improperly included in DSH Supplemental Security Income ("SSI") fraction,

2) *Issue No. 2: Dual Eligible Part C Days* – the Provider claims Dual Eligible Medicaid and Medicare Part C Days were improperly excluded from the DSH Medicaid fraction, and

[1] Provider's *Request for Appeal* (April 23, 2013), PRRB Case No. 13-1977.

3) *Issue No. 3: Medicaid Eligible Days* – the Provider claims Medicaid Eligible Days were improperly excluded from the numerator of the DSH Medicaid fraction.[2]

The Provider refers to two Audit Adjustment Nos. in support of these issues. The first is Audit Adjustment No. 5 which adjusted the DSH SSI Percentage, or the "[p]ercentage of SSI recipient patient days to Medicare Part A patient days." The second is Audit Adjustment No. 10 which updated the SSI % for Capital DSH in accordance with CMS Ruling 1498-R.[3]

The Medicare Administrative Contractor ("MAC") filed a jurisdictional challenge dated April 18, 2014, stating that the Board does not have jurisdiction over the Dual Eligible Part C Days excluded from the DSH Medicaid fraction issue because the MAC did not make an adjustment related to the days in question. The MAC also states the Board does not have jurisdiction over an issue discussed in the Provider's Preliminary Position Paper referred to as the exclusion of Medicaid Days attributable to patients entitled to Medicare Part A from the DSH SSI percentage. The MAC requests the Board to dismiss both issues.

Additionally, the Board is reviewing jurisdiction over Issue No. 3, DSH Medicaid Eligible Days.

Medicare Contractor's Position

The Medicare Contractor contends the Board lacks jurisdiction over Issue No. 2 addressing the exclusion of Dual Eligible Part C Days in the calculation of the DSH Medicaid percentage. The Medicare Contractor asserts the Provider has appealed from a Revised Notice of Program Reimbursement and is limited to appealing only those items adjusted with the RNPR. The Medicare Contractor states no adjustments were made to the DSH Medicaid fraction with the RNPR and the Provider does not meet the dissatisfaction requirement for Board jurisdiction, thus the Board lacks jurisdiction over this issue.

The Medicare Contractor also challenges the Board jurisdiction over Issue No. 4 addressing the exclusion of Medicare days attributable to patients entitled to Medicare Part A in the DSH SSI percentage computed by CMS. The Medicare Contractor states this appeal was received by the Board on April 25, 2013 and this issue was not timely added to the appeal in accordance with Board Rule 11. The Medicare Contractor alleges this issue was not in the Request for Appeal, and was first described by the Provider in its preliminary position paper received by the Medicare Contractor on December 20, 2013.

[2] Provider's *Request for Appeal* (Apr. 23, 2013) at 2-3.
[3] Provider's *Request for Appeal* (Apr. 23, 2013) at 33, 35.

BOARD'S DECISION:

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

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2013) provides in relevant part:

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

42 C.F.R. § 405.1889 (2013) explains the effect of a cost report revision:

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

Issue No. 2: Dual Eligible Part C Days in the Medicaid Percentage

This issue, along with Issue No. 1 addressing Part C Days in the DSH SSI fraction, was remanded to the MAC on November 17, 2020 pursuant to CMS Ruling 1739-R. As part of this November 17, 2020 remand, the Board confirmed jurisdiction over these issues. In this determination, the Board is clarifying that determination, namely that it has jurisdiction over the Provider's appeal from its revised NPR for the Part C Days issue in both the SSI/Medicare and Medicaid Fractions.

The Board clearly has jurisdiction of the Part C Days issue in the SSI fraction as the revised NPR effectuated a new SSI fraction that included an adjustment for those days pursuant to CMS Ruling 1498-R. Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[4] Thus, pursuant to *Allina*, if the provider were to be successful in its regulatory challenge, then the Part C days would have to be moved from the SSI fraction to the Medicaid fraction. Accordingly, the Board thus found that it has jurisdiction over the complete Part C days issue.

Issue No. 3: Medicaid Eligible Days

The Medicare Contractor did not challenge jurisdiction over this issue, however, the Board has review jurisdiction of this issue as it was not addressed in the Provider's Preliminary Position Paper (Dec. 20, 2013). The Provider describes the DSH Medicaid Eligible Days issue in its Request for Appeal as "…the MAC did not include in the numerator of the Medicaid fraction all patient days for which patients were eligible for medical assistance."[5]

For each cost issue appealed, providers are required to give a brief summary of the determination being appealed and the basis for dissatisfaction.[6] For cost issues relating to the DSH payment adjustment, which has multiple components, providers are required to appeal each separate DSH component as a separate issue which is described as narrowly as possible.[7]

With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

[4] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[5] Provider's *Request for Appeal* (Apr. 23, 2013) at 3.
[6] PRRB Rule 7 (July 1, 2015).
[7] PRRB Rule 8.1 (July 1, 2015).

> Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction *over **each** remaining matter at issue in the appeal*, and the merits of the provider's Medicare payment claims for each remaining issue.[8]

Board Rule 25 addresses Preliminary Position Papers. In this regard, it states the following, in pertinent part:

> **Rule 25 Preliminary Position Papers**
>
> 25.1 Content of Position Paper Narrative
>
> The text of the position papers must contain the elements addressed in the following subsections.
>
> 25.1.1 Provider's Position Paper
>
> A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.
>
> B. For *each* issue that has not been fully resolved, state the material facts that support the provider's claim.
>
> C. Identify the controlling authority, (e.g. statutes, regulations, policy or, case law) supporting the provider's position.
>
> D. Provide a conclusion applying the material facts to the controlling authorities.[9]

Further, Board Rule 25.3 states: "Any issue appealed, but not briefed by the Provider in its position paper will be considered ***withdrawn***."[10]

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate

[8] (Emphasis added.)
[9] (Italics emphasis added.)
[10] (Emphasis added.)

> conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may-
>
> (1) Dismiss the appeal with prejudice;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.

The Provider in this case included the DSH Medicaid Eligible Days issue in its Request for Appeal, however, the Provider does not address this issue in its Preliminary Position Paper (Dec. 20, 2013). The regulation at 42 C.F.R. § 405.1853(b)(2), as well as Board Rule 27 makes it clear that Preliminary Position Papers must address each remaining issue in the appeal. Accordingly. Board Rule 27.3 confirms that any issued not briefed will be considered withdrawn. For this reason the Board finds the DSH Medicaid Eligible Days no longer remains in the appeal as it was abandoned in the Provider's Preliminary Position Paper and is considered withdrawn.

Issue No. 4: Exclusion of Medicare Days Attributable to Patients Entitled to Medicare Part A in the SSI Fraction

The Medicare Contractor has challenged this issue as untimely added to this appeal. Effective August 21, 2008, following the appropriate notice and comment period, new Board regulations went into effect that limited the addition of issues to appeals.[11] 42 C.F.R. § 405.1835 provides in relevant part:

> (c) *Adding issues to the hearing request.* After filing a hearing request… a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board, only if…
>
> ***
>
> (3) The Board receives the request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) of this section.

[11] *See* 73 Fed. Reg. 30190 (May 23, 2008).

Additionally, Board Rule 11 states that a new issue may be added to an individual case only if the Provider 1) timely files a request to add the issues …, and 2) includes all supporting documentation…[12]

The final determination in this appeal is dated November 12, 2012. Applying the requirements means that new issues had to be added no later than 240 days after receipt of the Medicare Contractor's final determination, or July 15, 2013. A review of the record indicates that this issue was first discussed by the Provider in its Preliminary Position Paper filed with the Board on December 31, 2013. The Board finds this issue was not timely added, and therefore is not properly in this appeal.

Conclusion

The Board hereby closes Case No. 13-1977 and removes it from the Board's docket as there are no remaining issues in the appeal. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/23/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[12] Provider Reimbursement Review Board Rules, Part I, Rule 11 (2013), *available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf (last visited Jan. 7, 2019).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
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Elmhurst, IL 60126

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
Case Nos. 14-0401G, *et al*. (*see* attached list of 53 group cases)

Dear Mr. Putnam:

The above-referenced group appeals includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review ("Board" or "PRRB") must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On November 13, 2020, requests for Expedited Judicial Review ("EJR") were filed in the above-referenced appeals for the Part C Days issue. As set forth below is the Board's decision to deny the requests for EJR based on CMS Ruling 1739-R.

Statutory and Regulatory Background

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[1] 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].[2]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] 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.[5]

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*

[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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.
[5] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> *Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction. . .*[6]

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."[7] 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.[8]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[9] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[10] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010,

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[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.

CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[11]
The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[13] More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R. The Ruling provides notice that the Board and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement ("NPR") that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[14] The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[15] The Ruling explains that Medicare contractors will then calculate the provider's disproportionate share hospital (DSH) payment adjustment pursuant to the forthcoming final rule.[16]

[11] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[14] CMS Ruling 1739-R (Aug. 17, 2020).
[15] *Id*.
[16] *Id*.

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[17]

[17] CMS Ruling 1739-R, at 6-7.

Providers' Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[18] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[19] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Board's Decision and Analysis

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.

Pursuant to CMS Ruling 1739-R, the Board no longer has jurisdiction over appeals of this issue and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[20] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue, and as jurisdiction is a prerequisite for EJR, the Board denies the EJR requests. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board will be reviewing each of the group cases to determine if the Providers had "jurisdictionally proper" appeals prior to the Ruling (*i.e.*, determine if they are ripe for remand under 1739-R) and, as appropriate, remand pursuant to the Ruling.

[18] 69 Fed. Reg. at 49,099.
[19] *Allina* at 1109.
[20] (Emphasis added.)

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

Board Members Participating:

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

For the Board:

11/24/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Danene Hartley, National Government Services, Inc.
Bruce Snyder, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators

Attachment A

14-0401G	SRI 2007 Part C Days Group
14-3330G	SRI 2006 Part C Days Group
16-0323G	SRI Post 9/30/2004 - 2005 DSH Medicare + Choice Group
14-1564G	SRI FY 2008 SSI Fraction Medicare Part C Days Group
14-1574G	SRI FY 2008 Medicaid Fraction Medicare Part C Days Group
14-3331G	SRI 2009 Medicare Fraction Part C Days Group
14-3335G	SRI 2009 Medicaid Fraction Part C Days Group
15-0347G	SRI 2010 Medicare Fraction Part C Days Optional Group
15-0348G	SRI 2010 Medicaid Fraction Part C Days Optional Group
17-1320G	SRG 2014 DPP Medicare Part C Days Group
19-1466G	Strategic Reimb Group CY 2014 Medicaid Fraction Part C Days Group
19-1468G	Strategic Reimb Group CY 2014 Medicare Fraction Part C Days Group
14-1991GC	SRI Aurora FY 2006 Medicare Fraction Part C Days CIRP
14-1992GC	SRI Aurora FY 2006 Medicaid Fraction Part C Days CIRP
10-0360GC	Aurora HC 2007 Part C Days CIRP Group
14-1576GC	SRI Aurora FY 2007 SSI Fraction Medicare Part C CIRP
14-1578GC	SRI Aurora FY 2007 Medicaid Fraction Part C Days CIRP
14-3567GC	SRI Aurora 2008 Medicaid Fraction Part C Days CIRP Group
14-3568GC	SRI Aurora 2008 Medicare Fraction Part C Days CIRP Group
15-0213GC	SRI Aurora 2009 Medicare Fraction Part C Days CIRP Group
15-0215GC	SRI Aurora 2009 Medicaid Fraction Part C Days CIRP Group
15-0253GC	SRI Aurora FY 2010 Medicaid Fraction Part C Days CIRP Group
15-0254GC	SRI Aurora FY 2010 Medicare Fraction Part C Days CIRP Group
15-0239GC	SRI Aurora FY 2011 Medicare Fraction Part C Days CIRP Group
15-0240GC	SRI Aurora FY 2011 Medicaid Fraction Part C Days CIRP Group
16-2017GC	SRG Aurora 2012 Part C Days CIRP
20-0652GC	Advocate Aurora Health CY 2012 Medicare Part C Days CIRP Group
20-0653GC	Advocate Aurora Health CY 2012 Medicaid Fraction Part C Days CIRP Group
17-1299GC	SRG Aurora 2013 DPP Medicare Part C Days CIRP Group
14-3035GC	SRI Presence 2006 Medicare Fraction Part C Days CIRP Group
14-3036GC	SRI Presence 2006 Medicaid Fraction Part C Days CIRP Group
14-1397GC	SRI Presence FY 2007 SSI Medicare Part C Days CIRP
14-1554GC	SRI Presence FY 2007 Medicaid Fraction Part C Days CIRP
14-2857GC	SRI Presence 2008 Medicare Fraction Part C Days CIRP Group
14-2858GC	SRI Presence 2008 Medicaid Fraction Part C Days CIRP Group
14-2978GC	SRI Presence Health 2009 Medicare Fraction Part C Days CIRP Group

14-2979GC	SRI Presence Health 2009 Medicaid Fraction Part C Days CIRP Group
16-0130GC	SRI Presence 2011 Medicaid Fraction Part C Days CIRP Group
16-0136GC	SRI Presence 2011 Medicare Fraction Part C Days CIRP Group
16-1873GC	SRG Presence 2012 Medicare Fraction Part C Days CIRP Group
16-1875GC	SRG Presence 2012 Medicaid Fraction Part C Days CIRP Group
17-0817GC	SRG Presence 2013 DPP Medicare/Medicaid Part C Days CIRP Group
19-1742GC	St. Joseph Health System CY 2012 Medicare Fraction Part C Days CIRP Group
14-1555GC	SRI Summa FY 2007 SSI Fraction Part C Days CIRP
14-1562GC	SRI Summa FY 2007 Medicaid Fraction Part C Days CIRP
14-1566GC	SRI Summa FY 2008 Medicaid Fraction Medicare Part C Days CIRP
14-1580GC	SRI Summa FY 2008 SSI Fraction Part C Days CIRP
14-4240GC	SRI Summa 2009 Medicare Fraction Part C Days CIRP
14-4241GC	SRI Summa 2009 Medicaid Fraction Part C Days CIRP
16-1984GC	SRG Summa 2011 Medicare Fraction Part C Days CIRP Group
16-1985GC	SRG Summa 2011 Medicaid Fraction Part C Days CIRP Group
16-1829GC	SRI Summa 2012-2013 Medicaid Fraction Part C Days CIRP Group
16-1880GC	SRG Summa 2012-2013 Medicare Fraction Part C Days CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
13-2270GC Duke 2008 DSH Medicaid Fraction Part C CIRP Group
13-2290GC Duke Post 1498-R 2008 SSI Part C CIRP Group
14-1163GC Duke 2009 Medicaid Fraction Part C Days CIRP Group
14-1534GC Duke 2009 SSI Fraction Part C Days CIRP Group

Dear Ms. Webster:

The above-referenced four (4) common issue related party ("CIRP") group appeals includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review ("Board" or "PRRB") must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On November 4, 2020, requests for Expedited Judicial Review ("EJR") were filed in the above-referenced CIRP group appeals for the Part C Days issue. As set forth below is the Board's decision to deny the requests for EJR based on CMS Ruling 1739-R.

Statutory and Regulatory Background

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[1] 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].[2]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] 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.[5]

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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[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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.
[5] 69 Fed. Reg. 48918, 49099 (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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction. . .*[6]

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."[7] 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.[8]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[9] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[10] As a result of these rulemakings, Part C days were

[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.

required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[11]
The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[13] More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R. The Ruling provides notice that the Board and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement ("NPR") that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[14] The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[15] The Ruling explains that Medicare contractors will then calculate the provider's disproportionate share hospital (DSH) payment adjustment pursuant to the forthcoming final rule.[16]

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[11] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[14] CMS Ruling 1739-R (Aug. 17, 2020).
[15] *Id*.
[16] *Id*.

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[17]

[17] CMS Ruling 1739-R, at 6-7.

Providers' Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[18] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[19] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Board's Decision and Analysis

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.

Pursuant to CMS Ruling 1739-R, the Board no longer has jurisdiction over appeals of this issue and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[20] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue, and as jurisdiction is a prerequisite for EJR, the Board denies the EJR requests. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board will be reviewing each of the CIRP group cases to determine if the Providers had "jurisdictionally proper" appeals prior to the Ruling (*i.e.*, determine if they are ripe for remand under 1739-R) and, as appropriate, remand pursuant to the Ruling.

[18] 69 Fed. Reg. at 49,099.
[19] *Allina* at 1109.
[20] (Emphasis added.)

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

Board Members Participating:

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

For the Board:

11/27/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Laurie Polson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Jason Williams
Henry Ford Health System
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Detroit, MI 48202

Byron Lamprecht
WPS Government Health Administrators
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RE: ***EJR Denial and Remand Under CMS Ruling CMS-1739-R***
Henry Ford Wyandotte Hospital (Prov. No. 23-0146)
FYE 12/31/2006
Case No. 13-2592

Dear Mr. Williams and Mr. Lamprecht:

The above-referenced individual appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On November 18, 2020, a request for Expedited Judicial Review ("EJR") was filed in the above-referenced appeal for the Part C Days issue. As set forth below is the Board decision to deny the request for EJR and remand the case based on CMS Ruling 1739-R.

Statutory and Regulatory Background

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[1] 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].[2]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] 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.[5]

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*

[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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.
[5] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> *Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction. . .*[6]

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."[7] 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.[8]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[9] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[10] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[11]

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[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).
[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.
[11] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[13] More recently, in *Allina Health Services v. Price* ("*Allina II*"),[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R. The Ruling provides notice that the Provider Reimbursement Review Board ("PRRB") and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement ("NPR") that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[14] The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[15] The Ruling explains that Medicare contractors will then calculate the provider's disproportionate share hospital (DSH) payment adjustment pursuant to the forthcoming final rule.[16]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The

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with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).

[12] 746 F. 3d 1102 (D.C. Cir. 2014).

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

[14] CMS Ruling 1739-R (Aug. 17, 2020).

[15] *Id*.

[16] *Id*.

> Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[17]

Providers' Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[18] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[19] The Provider points out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In this case, the Provider contends that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the

[17] CMS Ruling 1739-R, at 6-7.
[18] 69 Fed. Reg. at 49,099.
[19] *Allina* at 1109.

Medicaid fraction. To obtain relief, the Provider seeks a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Provider maintains that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Board's Decision and Analysis

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.

Pursuant to CMS Ruling 1739-R, the Board no longer has jurisdiction over appeals of this issue and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[20] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue, and as jurisdiction is a prerequisite for EJR, the Board denies the EJR request. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board must, and has, reviewed the case to determine if the Provider had a "jurisdictionally proper" appeal prior to the Ruling (*i.e.*, determine if it is ripe for remand under 1739-R) and, as appropriate, remand pursuant to the Ruling.

The Board has reviewed the jurisdictional documentation and finds that the Provider has met the jurisdictional and procedural requirements under 42 U.S.C. § 1395oo, 42 C.F.R. Part 405, Subpart R, and Board Rules for the Medicare Part C issue. Consequently, pursuant to Ruling CMS-1739-R, the Board hereby remands the Medicare Part C issue to the Medicare Contractor for calculation of the Provider's DSH adjustment in accordance with the forthcoming final rule CMS will issue to govern treatment of these Medicare Part C patient days. As this is the last issue under appeal in this case, the case is now closed.

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.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/27/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[20] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
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Washington, DC 20006

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***

14-2726GC	Duke 2010 SSI Part C Days CIRP Group
14-2763GC	Duke 2010 Medicaid Fraction Part C Days CIRP
16-2350GC	Duke 2011 Medicaid Part C Days CIRP Group
16-2352GC	Duke 2011 SSI Part C Days CIRP Group
18-0193GC	Duke 2012 Medicaid Fraction Part C Days CIRP Group
18-0194GC	Duke 2012 SSI Part C Days CIRP Group
20-0573GC	Duke University CY 2013 Medicare Part C Days CIRP Group

Dear Ms. Webster:

The above-referenced seven (7) common issue related party ("CIRP") group appeals includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review ("Board" or "PRRB") must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On November 3, 2020, requests for Expedited Judicial Review ("EJR") were filed in the above-referenced appeals for the Part C Days issue. As set forth below is the Board's decision to deny the requests for EJR based on CMS Ruling 1739-R.

Statutory and Regulatory Background

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[1] 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].[2]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[3]

With the creation of Medicare Part C in 1997,[4] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under

[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] 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-

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.[5]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction. . .*[6]

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."[7] 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.[8]

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

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

[5] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[7] 69 Fed. Reg. at 49099.

[8] *Id.* (emphasis added).

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004, Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[9] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[10] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[11]
The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[12] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[13] More recently, in *Allina Health Services v. Price* ("*Allina II*")*,*[27] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[28] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[29]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R. The Ruling provides notice that the Board and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement ("NPR") that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for

[9] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[10] *Id*. at 47411.
[11] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[12] 746 F. 3d 1102 (D.C. Cir. 2014).
[13] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").

that fiscal year pre-dates the new final rule.[14] The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[15] The Ruling explains that Medicare contractors will then calculate the provider's disproportionate share hospital (DSH) payment adjustment pursuant to the forthcoming final rule.[16]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate

[14] CMS Ruling 1739-R (Aug. 17, 2020).
[15] *Id*.
[16] *Id*.

> Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[17]

Providers' Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[18] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[19] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina I*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Board's Decision and Analysis

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.

Pursuant to CMS Ruling 1739-R, the Board no longer has jurisdiction over appeals of this issue and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[20] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue, and as jurisdiction is a prerequisite for EJR, the Board denies the EJR requests. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board will be reviewing each of the CIRP group cases to determine if the Providers had "jurisdictionally proper" appeals prior to the Ruling (*i.e.*, determine if they are ripe for remand under 1739-R) and, as appropriate, remand pursuant to the Ruling.

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[17] CMS Ruling 1739-R, at 6-7.
[18] 69 Fed. Reg. at 49,099.
[19] *Allina* at 1109.
[20] (Emphasis added.)

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
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Susan A. Turner, Esq.

For the Board:

11/27/2020

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Laurie Polson, Palmetto GBA c/o National Government Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
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RE: ***EJR Determination***
14-2924GC QRS Providence 2010 DSH No Pay Part A Group
15-0932GC QRS Providence 2012 No Pay Part A Days Group
15-1677GC QRS UW Medicine 2011 No Pay Part A Days Group
17-0955GC QRS UW Medical 2013-2014 Part A No Pay Group
18-0680GC QRS UW Medicine 2015 Part A Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the referenced-above five (5) common issue related party ("CIRP") group appeals.[1] The Board's determination regarding EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these five CIRP groups consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C.

[1] The EJR also included Case Nos. 17-0844GC, 16-1992GC, 17-2232GC, 18-1113GC, 14-3271GC, 13-2350GC, and 13-2351GC. The Board is responding to the request for EJR in those cases under separate cover.

§ 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on February 25, 2020 and March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, on the date that the Board and its staff were required to begin telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted on February 25 and March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The group issue statement filed to establish each of these five CIRP groups is identical. First it is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days) and contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *included* in the ***Medicaid*** percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have *included* in the ***Medicaid*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[2]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

[2] (Emphasis added.)

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be included in the Medicaid percentage.*[3]

The EJR request characterizes the issue in these appeals as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the *Medicare* fraction of the Medicare Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare administrative contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[4]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[5]

[3] (Italics emphasis added and bold and underline emphasis in original.)
[4] Providers' EJR request at 2-3 (emphasis in original).
[5] *Id.* at 1.

Statutory and Regulatory Background

A. Adjustment for Medicare DSH

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 inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 . . . .[13]

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.[14]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).

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

> 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.[15]

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.[16]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

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[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id*.
[19] *Id*.
[20] *Id*.
[21] *Id*. at 27207-27208.

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[25] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[26] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [27] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[28]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[29] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[30]

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[22] *Id.* at 27207-08.
[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[31]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[32]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[33]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34] In order to effectuate this policy change, the FY 2005

[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[32] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[33] *Id*. at 49099 (emphasis added).
[34] *Id.*

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[35] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[39] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is

[35] *See id.* at 49099, 49246.
[36] (Emphasis added.)
[37] (Emphasis added.)
[38] *Id.*
[39] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[40] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[41] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[42] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[43] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[44] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[45] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[46]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[47] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[48] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[49] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[50] and that the regulation is procedurally invalid.[51]

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[40] *Id.* at 172.
[41] *Id.* at 190.
[42] *Id.* at 194.
[43] *See* 2019 WL 668282.
[44] 718 F.3d 914 (2013).
[45] 657 F.3d 1 (D.C. Cir. 2011).
[46] 718 F.3d at 920.
[47] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[48] *Id.* at 1141.
[49] *Id.*
[50] *Id. at 1162.*
[51] *Id. at 1163*

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[52] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[53] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[54] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[55] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[56] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[57] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[58] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e*., reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e*., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated

[52] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[53] *Id.* at 884.
[54] *Id.* at 884.
[55] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[56] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[57] *Id.* at 886.
[58] *Id.*

consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[59]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[60] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[61] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[62] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[63]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered

[59] Providers' EJR Request at 2.
[60] *Id.* at Section I.B.4.
[61] 746 F. 3d 1102 (D.C. Cir. 2014)
[62] Provider's EJR Request at Section I.B.5.
[63] *Id.* at 1107.

days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Provider's asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[64] The Providers' assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[65]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[66] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[67]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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[64] Providers' EJR Request at Section I.B.6.
[65] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[66] Providers' EJR request at 1.
[67] *Id.*

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2010-2013 and 2015.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[68] 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.[69]

On August 21, 2008, new regulations governing the Board were effective.[70] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[71] 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.[72]

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[68] 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.).
[69] *Bethesda*, 108 S. Ct. at 1258-59.
[70] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[71] 201 F. Supp. 3d 131 (D.D.C. 2016).
[72] *Id.* at 142.

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

A. Case No. 15-0932GC, Provider # 8 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/2012)

With respect to Provider # 8, Providence Portland Medical Center, its Notice of Program Reimbursement (NPR) was issued on November 4, 2014. To add this provider to the group, the Group Representative filed a "Model Form E: Request to Join an Existing Group Appeal: Direct Appeal from Final Determination" that is dated April 27, 2015. However, the Group Representative did not submit evidence of the date that the Board received the Provider's request to be directly added to this group appeal, as required by the Board's Rule 21.[73] Indeed, the Representative dropped a footnote for this provider on the Schedule of Providers confirming that the Representative "was unable to locate the delivery notification of the Model Form E."

The regulation, 42 C.F.R. § 405.1835(a)(3) (2015), defines the date of timely filing as "the date of receipt by the Board of the provider's hearing request [that] is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." The date of receipt by the Provider is presumed to be 5 days after the date of issuance of the contractor determination.[74] The regulation 42 C.F.R. § 405.1801(1) defines the date of receipt of a hearing as evidenced by one of the following:

> (i) Of delivery where the document or material is transmitted by a nationally-recognized next-day courier (such as the United States Postal Service's Express Mail, Federal Express, UPS, DHL, etc.); or
>
> (ii) Stamped "Received" by the reviewing entity on the document or other submitted material (where a nationally-recognized next-day courier is not employed). This presumption, which is otherwise conclusive, may be overcome if it is established by clear

[73] The Board's Rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRBRules_03_01_2013.pdf. This appeal was filed when the 2013 rules here in effect.
[74] 42 C.F.R. § 405.1801(a)(1)(iii) (Date of Receipt Means) (2015).

> and convincing evidence that the document or other material was actually received on a different date.[75]

To implement these regulations, Board Rule 21 (2013) requires that the documentation submitted with the Schedule of Providers include proof of delivery of the appeal and states:

> B. Date of Hearing Request
>
> 1. Schedule – Column B – Enter the date on which the original hearing request was filed with the Board (see Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request, also enter the date that the request to add the issue was filed.
>
> ****
>
> • If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the PRRB. See 42 C.F.R. § 405.1801(a) (2008).
>
> 2. Documentation – Tab B – A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, *if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue*. [March 2013][76]

Where a provider fails to include the a copy of the proof of delivery, the Board then defaults to the Board date stamp "Received" on the submission as permitted by 42 C.F.R. § 405.1801(a)(2).

In this case, the date stamp "received" for the appeal of Providence Portland Medical Center for the fiscal year December 12, 2012 is June 12, 2015.[77] Thus, the Board's records reflect that the Provider's request to directly join Case No. 15-0932GC was received on June 12, 2015.[78] With the allowance for the 5-day mailing period from the date the NPR was issued, the appeal was date stamped "received" in the Board's offices 215 days after the issuance of the NPR.[79] The Board's Rules regarding the submission of documentation and the proof of the date receipt of documentation have remained unchanged from the point the appeal was filed until the current

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[75] 42 CFR § 405.1801(a)(2) (2015).
[76] (emphasis added).
[77] *See* Enclosures for a Copy of the first page of Model Form E with the Board's date stamp.
[78] As evidenced by the date stamp on the document, see Attachment B.
[79] The actual number of days between 11/4/2014 and 6/12/15 is 220 days. Subtracting 5 days for delivery of the NPR results in a receipt date deemed to be 215 days.

time.[80] Consequently, the Group Representative had notice of the requirement that it is to submit proof of delivery of hearing request, absent that documentation, the Board will refer to its date stamp "received" to determine whether the appeal was timely.[81]

Based on the above, the Board finds that the appeal of Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/2012*)* was not filed with the Board within 180 days of the issuance of the NPR as required by 42 C.F.R. § 405.1835(a) and, hereby, dismisses the Provider from Case No. 15-0932GC. Since, pursuant to 42 C.F.R. § 405.1842(a), jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denies Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/2012) request for EJR. The jurisdictional determination for this Provider is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

B. Jurisdiction Limited to One Issue – the Dual Eligible Days Issue

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[82]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[83] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[84]

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[80] The Board's current Rules, effective August 29, 2018, contain the same requirements and are found in in Rules 21.3.1 and 21.3.2.

[81] In the Schedule of Providers attached to its EJR request, the Representative recognized its duty to provide the proof of delivery and admits that it "was unable to locate the delivery notification of the Model form E."

[82] (Emphasis added.)

[83] (Emphasis added.)

[84] (Emphasis added.)

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish each of these five CIRP groups clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be included in the Medicaid fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[85] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[86]

C. Jurisdiction for Remaining Providers and EJR

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[87] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

[85] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[86] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.
[87] *See* 42 C.F.R. § 405.1837.

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[88]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) 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 as stated above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

11/30/2020

X Clayton J. Nix

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

Enclosures: Attachment A - Schedules of Providers
Attachment B - First page of Model Form E for Providence Portland Medical Center

cc: John Bloom, Noridian Healthcare Services
Wilson Leong, FSS

[88] *Id.* at 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
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Arcadia, CA 91006

RE: ***EJR Determination***
15-1791GC QRS Multicare 2010 SSI Fraction Dual Eligible Days Group
15-1800GC QRS Multicare 2011 SSI Fraction Dual Eligible Days Group
15-1805GC QRS Multicare 2012 SSI Fraction Dual Eligible Days Group
16-1991GC QRS Multicare 2013 SSI Fraction Dual Eligible Days Group
15-1294GC QRS Providence 2010 SSI Fraction Dual Eligible Days Group
15-0433GC QRS Providence 2011 DSH-SSI Fraction Dual Eligible Days Group
17-0950GC QRS Providence 2014 SSI Part A Group
15-0790GC QRS UW Medicine 2011-2012 SSI-Dual Eligible Days Group
17-0958GC QRS UW Medicine 2013-2014 SSI Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced nine (9) common issue related party ("CIRP") group appeals.[1] The Board's determination regarding EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these nine CIRP groups consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employes access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish

[1] The EJRs filed for the above appeals on March 13, 2020 also included additional case numbers (16 in total). Those not addressed in this Board decision will be addressed under separate cover.

jurisdiction, *i.e*., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on February 25, 2020 and March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted on February 25 and March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The group issue statement filed to establish each of the CIRP groups is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[2]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

[2] (Emphasis added.)

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula*.[3]

The EJR request characterizes the group issue in these CIRP appeal as:

> [W]hether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligibles"*), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as "*noncovered days*") should be included in the Medicare fraction of the Medicare Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded from the *Medicare* fraction of the DSH adjustment, and instead be included in the *Medicaid* Fraction, as alleged by the providers.[4]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[5]

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[3] (Italics emphasis added and bold and underline emphasis in original.)
[4] Providers' EJR request at 2-3 (emphasis in original).
[5] *Id.* at 1.

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

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 inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 . . . .[13]

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.[14]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*
[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).

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

> 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.[15]

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.[16]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

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[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.* at 27207-27208.

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[25] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[26] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [27] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[28]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[29] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[30]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned

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[22] *Id.* at 27207-08.
[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*

to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[31]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[32]
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> ****
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> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[33]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34] In order to effectuate this policy change, the FY 2005

[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[32] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[33] *Id.* at 49099 (emphasis added).
[34] *Id.*

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[35] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that--*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[39] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is

[35] *See id.* at 49099, 49246.
[36] (Emphasis added.)
[37] (Emphasis added.)
[38] *Id.*
[39] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[40] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[41] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[42] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[43] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[44] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[45] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[46]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[47] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[48] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[49] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[50] and that the regulation is procedurally invalid.[51]

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[40] *Id.* at 172.
[41] *Id.* at 190.
[42] *Id.* at 194.
[43] *See* 2019 WL 668282.
[44] 718 F.3d 914 (2013).
[45] 657 F.3d 1 (D.C. Cir. 2011).
[46] 718 F.3d at 920.
[47] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[48] *Id.* at 1141.
[49] *Id.*
[50] *Id. at 1162.*
[51] *Id. at 1163*

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[52] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[53] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[54] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[55] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[56] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[57] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[58] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated

[52] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[53] *Id.* at 884.
[54] *Id.* at 884.
[55] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[56] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[57] *Id.* at 886.
[58] *Id.*

consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[59]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[60] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[61] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[62] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[63]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered

[59] Providers' EJR Request at 2.
[60] *Id.* at Section I.B.4.
[61] 746 F. 3d 1102 (D.C. Cir. 2014)
[62] Provider's EJR Request at Section I.B.5.
[63] *Id.* at 1107.

days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Provider's asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[64] The Providers' assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[65]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[66] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[67]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

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[64] Providers' EJR Request at Section I.B.6.
[65] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[66] Providers' EJR request at 1.
[67] *Id.*

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2010-2015.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[68] 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.[69]

On August 21, 2008, new regulations governing the Board were effective.[70] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[71] 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.[72]

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[68] 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.).
[69] *Bethesda*, 108 S. Ct. at 1258-59.
[70] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[71] 201 F. Supp. 3d 131 (D.D.C. 2016).
[72] *Id.* at 142.

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

A. Dismissal of 7 Providers in Case No. 17-0950 GC and 2 Providers in Case No. 15-0790GC for Lack of Proof of Delivery

Case No. 17-0950GC:
1 Providence Alaska Medical Center (Prov. No. 02-0001, FYE 12/31/14)
3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/14)
4 Providence Little Co. of Mary-Torrence (Prov. No. 05-0353, FYE 12/31/14)
5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/14)
6 Providence St. Patrick Hospital, (Prov. No. 27-0014, FYE 12/31/14)
10 Providence Milwaukie Hospital, (Prov. No. 38-0082, FYE 12/31/14)
20 Providence Williamette Falls (Prov. No. 38-0038, FYE 12/31/14)

Case No. 15-1790GC
#5 Valley Renton Medical Center (Prov. No. 50-0088, FYE 12/31/11)
#6 Valley Renton Medical Center (Prov. No. 50-0088, FYE 12/31/12)

The Board notes that the Representative failed to include proof of delivery of the hearing request for each of the above-identified nine (9) Providers as required by Board Rule 21.3.2.[73] Except for three of these Providers, the Group Representative confirmed on the Schedule of Providers that it "was unable to locate the delivery notification of the Model Form E" and, for the remaining three Providers, the Group Representative attached a notice that a package was assigned a shipping number and ***scheduled*** for shipment but this notice does not demonstrate that the package had in fact been delivered (much less actually received and sent by the delivery service).[74] This Rule requires that the jurisdictional documentation that accompanies the Schedule of Providers include proof of delivery of hearing request under Tab B for each Provider to establish the appeal was timely filed. The Rule states:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model

[73] The Board's rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.
[74] These three Providers were ## 3, 4, and 5 in Case No. 17-0950GC and the notice included for these Providers appears to be what is generated when a shipping label is generated for a shipment using a shipper's website and does not demonstrate that a package was actually received or sent by the shipper.

> Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, *include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.*[75]

Since the above nine Providers did not furnish the required proof of delivery for their original hearing request to establish that its appeal was timely filed under 42 C.F.R. § 405.1835(a), the Board hereby dismisses them from Case Nos. 17-0940GC and 15-0790GC as follows:

Case No. 17-0950GC:
1 Providence Alaska Medical Center (Prov. No. 02-0001, FYE 12/31/14)
3 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/14)
4 Providence Little Co. of Mary-Torrence (Prov. No. 05-0353, FYE 12/31/14)
5 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/14)
6 Providence St. Patrick Hospital, (Prov. No. 27-0014, FYE 12/31/14)
10 Providence Milwaukie Hospital, (Prov. No. 38-0082, FYE 12/31/14)
20 Providence Williamette Falls (Prov. No. 38-0038, FYE 12/31/14)

Case No. 15-0790GC
#5 Valley Renton Medical Center (Prov. No. 50-0088, FYE 12/31/11)
#6 Valley Renton Medical Center (Prov. No. 50-0088, FYE 12/31/12)

Since the above nine Providers did not establish it had a jurisdictional proper appeal before the Board as required by 42 C.F.R. § 405.1842(a),[76] the Board denies these nine Providers' request for EJR.[77]

B. Jurisdiction Limited to One Issue – the Dual Eligible Days Issue

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This*

[75] (Emphasis added.) The Board notes that its Rule is consistent with the requirement in 42 C.F.R. § 405.1837(a)(1) and (c) that each provider demonstrate it satisfies individually the requirement for a Board hearing which include the requirement that an appeal be timely filed with the Board.
[76] As a courtesy, the Board reviewed its records but, unlike certain other participants, was unable to locate records of this participant's direct add request.
[77] *See* 42 C.F.R. § 405.1842(a).

> *contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[78]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[79] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[80]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish each of these nine CIRP groups clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[81] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[82]

C. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:

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[78] (Emphasis added.)
[79] (Emphasis added.)
[80] (Emphasis added.)
[81] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[82] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the SSI fraction and does not dispute the Medicaid fraction.[83] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue

[83] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).

statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a class of patients. Either all days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[84]

With regard to the dual eligible days issue, all of the Medicare beneficiaries have Medicare Part A and, as such, it is clear that, as a *patient class*, days associated may not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay*** situations (*e.g.*, exhausted benefits and MSP) must these patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[85] and CMS Ruling 1727-R2 wherein multiple possible treatment of dual eligible days are discussed. Indeed, the relief requested appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[86]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being request in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42 C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[87]

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[84] 746 F.3d at 1108.
[85] 718 F.3d 914 (D.C. Cir. 2013).
[86] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).
[87] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group

D. Jurisdiction and EJR for the Remaining Providers

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[88] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i) 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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) 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 as noted above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.

[88] *See* 42 C.F.R. § 405.1837.

Board Members Participating:

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

FOR THE BOARD:

11/30/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: John Bloom, Noridian Healthcare Services
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***EJR Determination***
15-0929GC QRS Providence 2012 SSI-Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal.[1] The Board's determination regarding EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 4, 2020, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for this CIRP group consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

[1] The EJR also included a number of other case numbers. The Board is responding to the request for EJR in those cases under separate cover.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

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

RE: ***EJR Determination***
16-0605GC QRS Providence 2013 SSI Fraction Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal.[1] The Board's determination regarding EJR is set forth below.

Effect of COVID -19 on Board Operations and Staying of 30-day Period For Responding to EJR Requests

By letter dated April 4, 2020, the Board sent the Group Representative notice for this CIRP group that the 30-day time period for issuing an EJR had been stayed consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on February 25, 2020 and March 3, 2020, the Board did not receive

[1] The EJR also included a number of other cases. The Board is responding to the request for EJR in those cases under separate cover.

the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted on February 25 and March 3, 2020. Further, as the Parties have been made aware, the Board's offices have been temporarily relocated due to a building emergency and does not have full access to its paper files.[2] As a result, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute

The group issue statement filed to establish this CIRP group is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[3]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).

[2] *See* Board Alert 18. (Sept. 25, 2019).
[3] (Emphasis added.)

> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula*.[4]

The EJR request characterizes the group issue in this CIRP appeal as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the *Medicare* fraction of the Medicare Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[5]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[6]

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

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 inpatient prospective payment system ("IPPS").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

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[4] (Italics emphasis added and bold and underline emphasis in original.)
[5] Providers' EJR request at 2-3 (emphasis in original).
[6] *Id.* at 1.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[9] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[11] 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.[12] The DPP is defined as the sum of two fractions expressed as percentages.[13] 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 . . . .[14]

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.[15]

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.[16]

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[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(2)-(3).
[16] (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.[17]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[18] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[19]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[20] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[21] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[22]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[23] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[24] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A

[17] 42 C.F.R. § 412.106(b)(4).
[18] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.* at 27207-27208.
[23] *Id.* at 27207-08.
[24] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[25]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[26] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[27] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [28] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[29]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[30] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[31]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[32]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital

[25] 68 Fed. Reg. at 27208.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] *Id.*
[30] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[31] *Id.*
[32] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[33]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[34]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[35] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[36] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

[33] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[34] *Id.* at 49099 (emphasis added).
[35] *Id.*
[36] *See id.* at 49099, 49246.
[37] (Emphasis added.)

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[38]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[39]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[40] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[41] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[42] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[43] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[44] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[45] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[46] found that the Secretary's interpretation that that an individual is "entitled to

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[38] (Emphasis added.)
[39] *Id.*
[40] 317 F. Supp. 3d 168 (D.D.C. 2018).
[41] *Id.* at 172.
[42] *Id.* at 190.
[43] *Id.* at 194.
[44] *See* 2019 WL 668282.
[45] 718 F.3d 914 (2013).
[46] 657 F.3d 1 (D.C. Cir. 2011).

benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[47]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[48] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[49] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[50] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[51] and that the regulation is procedurally invalid.[52]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[53] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[54] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[55] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[56] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[57] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[58] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to

[47] 718 F.3d at 920.
[48] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[49] *Id.* at 1141.
[50] *Id.*
[51] *Id. at 1162.*
[52] *Id. at 1163*
[53] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[54] *Id.* at 884.
[55] *Id.* at 884.
[56] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[57] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[58] *Id.* at 886.

[Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[59] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[60]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[61] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[62] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a

[59] *Id.*
[60] Providers' EJR Request at 2.
[61] *Id.* at Section I.B.4.
[62] 746 F. 3d 1102 (D.C. Cir. 2014)

logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[63] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[64]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Provider's asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[65] The Providers' assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[66]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[67] In

[63] Provider's EJR Request at Section I.B.5.
[64] *Id.* at 1107.
[65] Providers' EJR Request at Section I.B.6.
[66] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[67] Providers' EJR request at 1.

making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[68]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

Decision of the Board

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

Jurisdiction

The participants in this group have filed appeals involving fiscal year 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[69] 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.[70]

On August 21, 2008, new regulations governing the Board were effective.[71] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell*

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[68] *Id.*
[69] 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.).
[70] *Bethesda*, 108 S. Ct. at 1258-59.
[71] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[72] 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.[73]

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

A. Dismissal of 8 Providers for Lack of Proof of Delivery

#1 Providence Alaska Medical Center (Prov. No. 02-0001, FYE 12/31/13)
#2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13)
#4 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/13)
#5 Providence St. Patrick Hospital (Prov. No. 27-0014, FYE 12/31/13)
#6 Providence St. Vincent Med. Ctr. (Prov. No. 38-0004, FYE 12/31/13)
#9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/13)
#10 Providence Medford Medical Center (Prov. No. 38-0075, FYE 12/31/13)
#21 Providence Milwaukie Hospital (Prov. No. 38-0082, FYE 12/31/13)

The Board notes that the above eight (8) Providers failed to include proof of delivery of their "Model Form E[s]: Request to Join an Existing Group Appeal: Direct Appeal from Final Determination" as required by Board Rule 21.3.2.[74] For ## 1, 2, 5, 6, 10, and 21, the Group Representative confirmed on the Schedule of Providers with a footnote 1 that it "was unable to locate the delivery notification of the Model Form E." Notwithstanding, for #21 Providence Milwaukie Hospital (Prov. No. 38-0082, FYE 12/31/13), the Group Representative did include under Tab B a Board Acknowledgement and Critical Due Dates letter (Acknowledgement letter) for Case No. 16-1479 which is an individual appeal for this Provider. However, this Acknowledgement letter is not applicable because Providence Milwaukie Hospital was ***directly added*** to this group appeal from the issuance of its NPR and, accordingly, does not demonstrate the date the Board received the Model Form E (*i.e.*, the filing that directly added this provider to the current group case). For #4, the Group Representative attached a notice from United Parcel Service ("UPS") that a package was assigned a shipping number and ***scheduled*** for shipment but

[72] 201 F. Supp. 3d 131 (D.D.C. 2016).
[73] *Id.* at 142.
[74] The Board's rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.

this notice does not demonstrate that the package had in fact been delivered (much less actually received by UPS and sent using that delivery service).[75] For #9, the Representative failed to provide any proof of delivery documentation for #9 under Tab B (and also did not include a footnote 1 on the Schedule of Providers confirming this).

Board Rule 21.3.2 requires that the jurisdictional documentation that accompanies the Schedule of Providers include proof of delivery of hearing request under Tab B for each Provider to establish the appeal was timely filed. The Rule states that:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, *include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.*[76]

Since the Providers did not furnish proof of delivery for their original hearing request to establish that their appeals were timely filed under 42 C.F.R. § 405.1835(a) the Board hereby dismisses the following eight Providers from Case No. 16-0605GC:

#1 Providence Alaska Medical Center (Prov. No. 02-0001, FYE 12/31/13)
#2 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/13)
#4 Providence Tarzana Medical Center (Prov. No. 05-0761, FYE 12/31/13)
#5 Providence St. Patrick Hospital (Prov. No. 27-0014, FYE 12/31/13)
#6 Providence St. Vincent Med Ctr (Prov. No. 38-0004, FYE 12/31/13)
#9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/13)
#10 Providence Medford Medical Center (Prov. No. 38-0075, FYE 12/31/13)
#21 Providence Milwaukie Hospital (Prov. No. 38-0082, FYE 12/31/13)

As these eight Providers did not establish they had a jurisdictional proper appeal before the Board as required by 42 C.F.R. § 405.1842(a), the Board denies these eight Providers request for EJR.

B. *Alternative Basis for Dismissal of #9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/13) – Lack of Letter of Representation*

As discussed above, the Board dismissed #9 Providence Portland Medical Center (Provider No. 38-0061, FYE 12/31/13) due to the Representative's failure to furnish the proof of delivery of the appeal request. The lack of a proper letter of representation is an alternative and independent

[75] This notice appears to be what is generated when a shipping label is generated for a shipment using a shipper's website and does not demonstrate that a package was actually received or sent by the shipper.
[76] (Emphasis added.) The Board notes that its Rule is consistent with the requirement in 42 C.F.R. § 405.1837(a)(1) and (c) that each provider demonstrate it satisfies individually the requirement for a Board hearing which include the requirement that an appeal be timely filed with the Board.

basis for dismissal of #9 Providence Portland Medical Center from this appeal and denial of this provider's EJR request.

Board Rule 21.9.2 states that the Group Representative must "[i]nclude the letter of representation which must reflect the provider's fiscal year under appeal in this case and the issue" under Tab H of each Provider's jurisdictional documents. In the case of #9 Providence Portland Medical Center, the Group Representative file a Model Form E dated February 10, 2018, *to directly add* the Provider to this dual eligible days group appeal where the direct add serves as the Provider's appeal. However, the representation letter under Tab H is July 18, 2018 and stated that the scope of Quality Reimbursement Services representation was limited to the Supplemental Security Income (SSI) Percentage and Medicare Part A Days issues. However, the representation letter is dated several months after the Provider's appeal by direct add was filed. In this regard, the Board Rules 5.4 and 6.4 state:

> **5.4 – Designation of Representative Letter**
>
> The letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider. The letter must reflect the Provider's fiscal year under appeal and must also contain the following contact information: name, organization, address, telephone number, fax number and e-mail address of the representative.
>
> * * * *
>
> **6.4 – Certifications**
>
> An authorized representative of the Provider must sign the appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider.

To this end, the instructions for the Model Form E that the Representative used for this Provider include the following instructions at Paragraph 9:

> **9. Representative Information (if applicable):**
> **NOTE**: If you are filing as a representative, YOU **MUST** ATTACH A LETTER SIGNED BY THE PROVIDER AUTHORIZING REPRESENTATION UNDER A **TAB LABELED 2**. *See* Rule 5.4.[77]

As a result of the lack of a proper representation letter, the Board finds that the Representative was not authorized to file the appeal in the first instance. Accordingly, the lack of a proper letter of representation is an alternative and independent basis for dismissal of #9 Providence Portland

[77] (Emphasis in original.)

Medical Center (Prov. No. 38-0061, FYE 12/31/13) from this appeal and denial of this provider's EJR request.

C. Jurisdiction Limited to One Issue – the Dual Eligible Days Issue

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[78]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[79] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[80]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish each of these five CIRP groups clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R.

[78] (Emphasis added.)
[79] (Emphasis added.)
[80] (Emphasis added.)

§ 405.1837(f)(1).[81] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[82]

D. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—

[81] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.

[82] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the Medicare fraction and does not dispute the Medicaid fraction.[83] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a class of patients. Either all days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[84]

With regard to the dual eligible days issue, all of the Medicare beneficiaries have Medicare Part A and, as such, it is clear that, as a *patient class*, days associated may not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay*** situations (*e.g.*, exhausted benefits and MSP) must these patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[85] and CMS Ruling 1727-R2 wherein multiple possible treatment of dual eligible days are discussed. Indeed, the relief requested appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[86]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH

[83] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).
[84] 746 F.3d at 1108.
[85] 718 F.3d 914 (D.C. Cir. 2013).
[86] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).

formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being request in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42 C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[87]

E. Jurisdiction and EJR for the Remaining Providers

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to dual eligible days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[88] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

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 remaining participants in these group appeals are entitled to a hearing before the Board;

2) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i) 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

[87] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.
[88] *See* 42 C.F.R. § 405.1837.

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Providers' request for EJR for the issue and the subject years as noted above. The remaining Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

11/30/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The group issue statement filed to establish this CIRP group is entitled "Disproportionate Share Hospital Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and it contains the following description of the issue:

> Whether patient days associated with Medicare Part A and Title XIX patients should be *excluded* from the SSI or ***Medicare*** fraction of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the MAC should have excluded from the SSI or ***Medicare*** fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[2]

The group issue statement then provides the following "Statement of the Legal Basis":

> The Provider contends that the MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused

[2] (Emphasis added.)

> to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula*.[3]

The EJR request characterizes the group issue in this CIRP appeal as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligible*"), and for whom Medicare has not made payment for that inpatient stay (hereinafter referred to as *"noncovered days")* should be included in the Medicare fraction of the *Medicare* Disproportionate Share (DSH) adjustment, as alleged by the MAC [Medicare Administrative Contractor], or should be excluded *Medicare* fraction of the DSH adjustment, and instead included in the *Medicaid* fraction . . . .[4]

The EJR request specifies that the relief being requested is that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[5]

Statutory and Regulatory Background: Medicare DSH Payment

A. Adjustment for Medicare DSH

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 inpatient prospective payment system ("IPPS").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

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[3] (Italics emphasis added and bold and underline emphasis in original.)
[4] Providers' EJR request at 2-3 (emphasis in original).
[5] *Id.* at 1.
[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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 . . . .[13]

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.[14]

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.[15]

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[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (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.[16]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A

[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.* at 27207-27208.
[22] *Id.* at 27207-08.
[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[25] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[26] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [27] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[28]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[29] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[30]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[31]

In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and stated:

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital

[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*
[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[32]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[33]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[35] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

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[32] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[33] *Id.* at 49099 (emphasis added).
[34] *Id.*
[35] *See id.* at 49099, 49246.
[36] (Emphasis added.)

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[39] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[40] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[41] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[42] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[43] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[44] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[45] found that the Secretary's interpretation that that an individual is "entitled to

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[37] (Emphasis added.)
[38] *Id.*
[39] 317 F. Supp. 3d 168 (D.D.C. 2018).
[40] *Id.* at 172.
[41] *Id.* at 190.
[42] *Id.* at 194.
[43] *See* 2019 WL 668282.
[44] 718 F.3d 914 (2013).
[45] 657 F.3d 1 (D.C. Cir. 2011).

benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[46]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[47] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[48] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[49] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[50] and that the regulation is procedurally invalid.[51]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[52] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[53] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[54] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[55] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[56] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[57] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to

[46] 718 F.3d at 920.
[47] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[48] *Id.* at 1141.
[49] *Id.*
[50] *Id. at 1162.*
[51] *Id. at 1163*
[52] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[53] *Id.* at 884.
[54] *Id.* at 884.
[55] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[56] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[57] *Id.* at 886.

[Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[58] Accordingly, the Ninth Circuit to the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force).

As of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Request for EJR

The Providers contend that the non-covered patient, *i.e.*, days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make payment for their hospital stays because the patient's Medicare patient days were exhausted or because a third party made payment, should be excluded from the Medicare fraction of the DSH fraction. The Providers maintain *in their EJR request* that these non-covered patient days should be treated consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[59]

The Providers explain that the applicable regulations require that non-covered patient days be included in the Medicare fraction due to the change made to the regulations effective October 1, 2004. This was accomplished by the deletion of the word "covered" where it had previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). As a result of this change, the regulation now requires the inclusion in the Medicare fraction of both exhausted benefit and Medicare secondary payment days associated with patient discharges occurring on or after October 1, 2004.

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPPS Final Rule and that this revision should be vacated due to *procedural* violations of the Administrative Procedures Act ("APA").[60] In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[61] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The D.C. Circuit concluded that the Part C days regulation was not a

[58] *Id.*
[59] Providers' EJR Request at 2.
[60] *Id.* at Section I.B.4.
[61] 746 F. 3d 1102 (D.C. Cir. 2014)

logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers put forward another challenge to the procedural validity of the revision to § 412.106(b)(2)(i) by arguing that the Secretary's FY 2005 regulations requiring inclusion of the non-covered days in the Medicare fraction were not the product of reasoned decision-making.[62] The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[63]

Accordingly, the Providers maintain that the Secretary denied the public a meaningful opportunity to comment on the proposed regulations. There was nothing in the proposed regulations that suggested the possibility of anything other than the inclusion of non-covered days in the Medicare fraction or inclusion of non-covered days in the Medicaid fraction. As a result, the Providers maintain, the public was deprived of a meaningful opportunity to comment.

Accordingly, the Provider's asserted that the Secretary's regulations requiring inclusion of post-2004 non-covered days in the Medicare fraction must be vacated and, as a result, the pre-FY 2005 regulations would apply.[64] The Providers' assert that "These pre-FY 2005 regulations command exclusion of all non-covered days from the *Medicare* fraction" and that "if those day must be excluded from the Medicare faction [*sic* fraction], then they must necessarily be included in the Medicaid fraction."

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[65]

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[66] In

[62] Provider's EJR Request at Section I.B.5.
[63] *Id.* at 1107.
[64] Providers' EJR Request at Section I.B.6.
[65] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[66] Providers' EJR request at 1.

making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[67]

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that, as a matter of law , 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

Decision of the Board

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

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[68] 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.[69]

On August 21, 2008, new regulations governing the Board were effective.[70] 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

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[67] *Id.*
[68] 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.).
[69] *Bethesda*, 108 S. Ct. at 1258-59.
[70] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[71] 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.[72]

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

A. Dismissal of #3 St. Joseph Medical Center (Prov. No. 05-0235, FYE 12/31/12)

The Board notes that Participant #3 St. Joseph Medical Center failed to include proof of delivery of its "Model Form E: Request to Join an Existing Group Appeal: Direct Appeal from Final Determination" as required by Board Rule 21.3.2.[73] Rather, the Group Representative attached a notice that a package was assigned a shipping number and ***scheduled*** for shipment but this notice does not demonstrate that the package had in fact been delivered (much less actually received and sent by the delivery service).[74] This Rule requires that the jurisdictional documentation that accompanies the Schedule of Providers include proof of delivery of hearing request under Tab B for each Provider to establish the appeal was timely filed. The Rule states that:

> A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, *include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.*[75]

[71] 201 F. Supp. 3d 131 (D.D.C. 2016).
[72] *Id.* at 142.
[73] The Board's rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.
[74] This notice appears to be what is generated when a shipping label is generated for a shipment using a shipper's website and does not demonstrate that a package was actually received or sent by the shipper.
[75] (Emphasis added.) The Board notes that its Rule is consistent with the requirement in 42 C.F.R. § 405.1837(a)(1) and (c) that each provider demonstrate it satisfies individually the requirement for a Board hearing which include the requirement that an appeal be timely filed with the Board.

Since the Provider did not furnish proof of delivery for their original hearing request to prove that its appeal was timely filed under 42 C.F.R. § 405.1835(a),[76] the Board hereby dismisses #3 St. Joseph Medical Center (Prov. No. 05-0235, FYE 12/31/12) from Case No. 15-0929GC. Since the Provider did not establish it had a jurisdictional proper appeal before the Board as required by 42 C.F.R. § 405.1842(a), the Board denies the Providers request for EJR.

B. Dismissal of # 7 Providence St. Vincent Medical Center (Prov. No. 38-0004, FYE 12/31/12) and # 9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/12)

The Group Representative did not furnish proof of delivery for the original hearing requests for Participant ## 7 Providence St. Vincent Medical Center and 9 Providence Portland Medical Center as required by Board Rule 21.3.2, set forth above. Both providers made their appeal request through "Model Form E[s]: Request to Join an Existing Group Appeal: Direct Appeal from Final Determination" ("Model Form E") and the Group Representative confirmed on the Schedule of Providers that it "was unable to locate the delivery notification of the Model Form E" for these two providers. The Model Form E for # 7 Providence St. Vincent is dated February 24, 2015 and the Model Form E for # 9 Providence Portland Medical Center is dated April 27, 2015. Although the Group Representative failed to submit the required proof of delivery, the Board's records reflect that:

1. The Model Form E for # 7 Providence St. Vincent was date stamped received by the Board on March 2, 2015 (198 days after the issuance of the NPR); and

2. The Model Form E for # 9 Providence Portland Medical Center was date stamped received by the Board on June 12, 2015 (220 days after the issuance of the NPR).

The regulation, 42 C.F.R. § 405.1835(a)(3) (2015), defines the date of timely filing as "the date of receipt by the Board of the provider's hearing request [that] is no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." The date of receipt by the Provider is presumed to be 5 days after the date of issuance of the contractor determination.[77] The regulation 42 C.F.R. § 405.1801(1) defines the date of receipt of a hearing as evidenced by one of the following:

> (i) Of delivery where the document or material is transmitted by a nationally-recognized next-day courier (such as the United States Postal Service's Express Mail, Federal Express, UPS, DHL, etc.); or
>
> (ii) Stamped "Received" by the reviewing entity on the document or other submitted material (where a nationally-recognized next-day courier is not employed). This presumption, which is

[76] As a courtesy, the Board reviewed its records but, unlike certain other participants, was unable to locate records of this participant's direct add request.
[77] 42 C.F.R. § 405.1801(a)(1)(iii) (Date of Receipt Means) (2015).

> otherwise conclusive, may be overcome if it is established by clear and convincing evidence that the document or other material was actually received on a different date.[78]

To implement these regulations, Board Rule 21 (2013) requires that the documentation submitted with the Schedule of Providers include prove of delivery of the appeal and states:

> B. Date of Hearing Request
>
> 1. Schedule – Column B – Enter the date on which the original hearing request was filed with the Board (see Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request, also enter the date that the request to add the issue was filed.
>
> ****
>
> • If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the PRRB. See 42 C.F.R. § 405.1801(a) (2008).
>
> 2. Documentation – Tab B – A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, *if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue*. [March 2013][79]

Where a provider fails to include the a copy of the proof of delivery, the Board defaults to the Board date stamp "Received" on the submission as permitted by 42 C.F.R. § 405.1801(a)(2).[80]

The Board's records reflect that the Model Form E for # 7 Providence St. Vincent was date stamped received by the Board on March 2, 2015 (198 days after the issuance of the NPR) and the Model Form E for # 9 Providence Portland Medical Center date stamped received June 12, 2015 (220 days after the issuance of the NPR). With the allowance for the 5-day mailing period from the date the NPR was issued, the appeal of #7 was date stamped "received" in the Board's offices 193 days after the issuance of the NPR and the appeal of # 9 Providence Portland Medical Center was date stamped received 215 days after the issuance of the NPR.[81] The Board's Rules regarding the submission of documentation and the proof of the date receipt of

[78] 42 CFR § 405.1801(a)(2) (2015).
[79] (Emphasis added.)
[80] *See* Enclosures for a Copy of the first page of Model Form E with the Board's date stamps.
[81] The actual number of days between 11/4/2014 and 6/12/15 is 220 days. Subtracting 5 days for delivery of the NPR results in a receipt date deemed to be 215 days.

documentation have remained unchanged from the point the appeal was filed until the current time.[82] Consequently, the Group Representative had notice of the requirement that it is to submit proof of delivery of hearing request, absent that documentation, the Board will refer to its date stamp "received" to determine whether the appeal was timely.

Based on the above, the Board finds that the appeals of # 7 Providence St. Vincent Medical Center (Prov. No. 38-0004, FYE 12/31/12) and # 9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/12) were not filed within 180 days of the issuance of the NPR as required by 42 C.F.R. § 405.1835(a) and hereby dismisses the Providers from Case No. 15-0929GC. In addition, since, pursuant to 42 C.F.R. § 405.1842(a), jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denies request for EJR # 7 Providence St. Vincent Medical Center (Prov. No. 38-0004, FYE 12/31/12) and # 9 Providence Portland Medical Center (Prov. No. 38-0061, FYE 12/31/12). The jurisdictional determination for these Providers is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

C. Dismissal of #2 Providence Little Company of Mary (Prov. No. 05-0078, FYE 12/31/2012), #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2012), #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2012)

The above three Providers each established an individual appeal with the Board and then requested transfer to this CIRP group. However, the information included with the Schedule of Providers on these three Provider was incomplete. Specifically, the copy of Model Form A-Individual Appeal Request under Tab B of the jurisdictional documents is incomplete because the statement of the issue in the Provider's respective individual appeal (from which they requested transfer) was omitted. The statement of the issue would confirm whether the dual eligible days issue was timely and properly appealed in the Providers' respective individual appeal prior to transfer to the current group appeal. Board Rule 21.3.2 requires:

> *A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), <u>including the issue statement</u>, or other written requests filed prior to* the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.[83]

Without a copy of the issue statement, the Board cannot ascertain whether the transfer of the issue to the current group appeal was proper.[84] A provider must demonstrate that the issue it

[82] The Board's current Rules, effective August 29, 2018, contain the same requirements and are found in in Rules 21.3.1 and 21.3.2.
[83] (emphasis added)
[84] 42 C.F.R. § 405.1837(d)(2)(iii) permits(d) to take the following actions as part of the Board's preliminary response to group appeal hearing requests.
(1) Upon receipt of a group appeal hearing request, the Board must take any necessary ministerial steps.
(2) The steps, include, for example—

wishes to transfer from an individual appeal was timely appealed in the individual appeal before it is transferred to group appeal involving the issue.

Since #2 Providence Little Company of Mary (Prov. No. 05-0078, FYE 12/31/2012), #4 Providence Holy Cross Medical Center (Prov. No. 05-0278, FYE 12/31/2012), and #5 Providence Little Company of Mary-Torrance (Prov. No. 05-0353, FYE 12/31/2012) failed to include the statement of the issue under Tab B of the jurisdictional documents to demonstrate the issue was timely appealed as required by 42 C.F.R. § 405.1835(a) and properly part of the CIRP group, the Board hereby dismisses the Providers from the appeal. Since jurisdiction over a provider in a group appeal is a requisite to granting a request for EJR, the Board denies the Providers' request for EJR.[85]

D. Jurisdiction Limited to One Issue – the Dual Eligible Days Issue

The Board notes that, on first page of their EJR request, the Providers include another issue which states:

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[86]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[87] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other*

****

(iii) If applicable, transferring a specific matter at issue from a single provider appeal filed under § 405.1835 of this subpart to a group appeal filed under this section.

[85] *See* 42 C.F.R. § 405.1842(a).
[86] (Emphasis added.)
[87] (Emphasis added.)

questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal . . . ."[88]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish this CIRP group clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[89] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[90]

E. Scope of Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) (2014) specifies that request for a group appeal contain the following:

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request must include all of the following:
>
> (1) A demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its contractor or Secretary determination under appeal, including an account of—
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item;
>
> (ii) **How and why the provider believes Medicare payment must be determined differently for each disputed item**; and

[88] (Emphasis added.)
[89] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[90] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.

> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) of this section, and **a precise description** of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with § 405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Providers' issue statement filed to establish this CIRP group only appealed the Medicare fraction and does not dispute the Medicaid fraction.[91] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group issue statement only requested the relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

In this regard, the Providers EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a class of patients. Either all days associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[92]

With regard to the dual eligible days issue, all of the Medicare beneficiaries have Medicare Part A and, as such, it is clear that, as a *patient class*, days associated may not be included *in toto* from the Medicare fraction. Rather, the Providers are asserting that only in certain ***no-pay***

[91] The only references to the Medicaid fraction are statements of alleged facts and do not include any assertion that the Medicaid fraction was *incorrectly* calculated (much less express dissatisfaction with the Medicaid fraction).
[92] 746 F.3d at 1108.

situations (*e.g.*, exhausted benefits and MSP) must these patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[93] and CMS Ruling 1727-R2 wherein multiple possible treatment of dual eligible days are discussed. Indeed, the relief requested appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[94]

Based on the above, the Board finds that the Providers' EJR request is limited to the relief requested in the group issue statement, namely that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula." As a result, the Board strikes those portions of the Representative's EJR request requesting the relief that "non-covered patient days should be included in the denominator of the Medicaid fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."

The Board notes that the relief being request in the group issue statement for this CIRP group is not inconsistent with the Ninth Circuit's decision in *Empire* wherein it relied on the Ninth Circuit's earlier decision in *Legacy* to: (1) find that the FY 2005 IPPS Final Rule's revision to 42 C.F.R. § 412.106(b)(2)(i) was *substantively* invalid and (2) reinstate the regulation or rule previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[95]

F. Jurisdiction and EJR for the Remaining Providers

The Board has determined that the *remaining* participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[96] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

The Board finds that it lacks the authority to grant the relief sought by the Providers, namely a finding that 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid. Consequently, the Board finds that EJR is appropriate.

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[93] 718 F.3d 914 (D.C. Cir. 2013).
[94] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years ealier in *Edgewater"*).
[95] The Board notes that, even though subsequent to the EJR request being filed the Ninth Circuit issued its decision in *Empire*, the Group Representative did not seek to supplement its EJR request (notwithstanding the fact that the Group Representative was the representative for that case when it was before the Board). Rather, the Group Representative filed a request on October 29. 2020 requesting that the Board issue a decision on its EJR request by November 30, 2020.
[96] *See* 42 C.F.R. § 405.1837.

Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i) 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) codifying the Medicare dual eligible days policy adopted in the FY 2005 IPPS final rule is valid and to provide the requested relief that no-pay dual eligible days "be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula."

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) 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 as noted above. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

11/30/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers, Model Form E's

cc: John Bloom, Noridian Healthcare Service,
Wilson Leong, FSS