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 O'Connell
SunStone Consulting, LLC
357 Futurity Drive
Camp Hill, PA 17011

RE: ***Request for Reconsideration of Dismissal***
SunStone Consulting FFY 2018 Understatement of Documentation and Coding Repayment Group
Case No. 19-0108G

Dear Mr. O'Connell:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced appeal in response to the Request for Reconsideration of Dismissal ("Reconsideration Request") filed by the Group Representative, SunStone Consulting ("SunStone") on May 28, 2020. As explained more fully below, the Board hereby denies SunStone's request for reconsideration of the Board's dismissal of this case.

Pertinent Facts:

On October 24, 2018, SunStone submitted a Request to Form Group Appeal ("RFH") in order to establish this group appeal, *i.e.*, Case No. 19-0108G. This group appeal is based on a Federal Register notice published August 14, 2017.[1]

On November 6, 2018, the Board issued the Case Acknowledgment and Critical Due Dates Notice ("Critical Due Dates Notice") and set the Preliminary Position Paper ("PPP") deadline for the Providers on December 23, 2019. The Critical Due Dates Notice instructed SunStone that failure to timely file the PPP would result in dismissal of the appeal:

> The parties are responsible for pursuing the appeal in accordance with the Board's Rules. *The parties **must** meet the following due dates regardless of any outstanding jurisdictional challenges, motions, or subpoena requests*. If the Group misses any of its due dates, the Board ***will dismiss*** the appeal. If the Medicare Contractor fails to meet its deadlines, the Board will take actions described under 42 C.F.R. § 405.1868.[2]

[1] *See* 82 Fed. Reg. 37990 (Aug. 14, 2017).
[2] (Footnote omitted and emphasis added.)

In its "30 days letter" dated November 27, 2018, the Medicare administrative contractor ("MAC") notified the Board that the group properly consisted of one issue, but asserted that the appeal was untimely based on the date of Federal Register Notice being appealed.

SunStone then failed to file the group's PPP by the December 23, 2019 PPP filing deadline. However, sixteen days later on January 8, 2020, Sunstone filed the late PPP. Although the Board had not yet dismissed appeal, two days later on January 10, 2020, SunStone submitted a "reconsideration request" entitled "Motion to Reinstate," asking the Board to accept the late PPP.

On February 17, 2020, the MAC submitted a jurisdictional challenge stating again that the provider's group appeal was filed late from the Federal Register Notice and that the Providers were not properly transferred to the appeal. On February 18, 2020, the Provider responded to the jurisdictional challenge.

On April 21, 2020, the Board considered the prematurely-filed reconsideration request that SunStone filed in anticipation of dismissal and determined that dismissal was proper. In dismissing the group appeal pursuant to its authority under 42 C.F.R. § 405.1868, the Board found that SunStone failed to file the group's PPP with the Board prior to the tolling of the December 23, 2019 filing deadline specified in the Critical Due Dates Notice and that SunStone had not established good cause under Board Rule 47.3 for the late filing.[3]

On May 28, 2020, the Providers filed a Motion for Reconsideration, reiterating previously asserted contentions, based, in part, on the nature of the appeal itself, alleged ambiguity in the Board Rules, the confusion that resulted from transferring the individual appeals to an optional group appeal, the concurrence of the MAC, and previous positions allegedly taken by the Board in similar situations.[4]

Board's Determination:

Board Rule 47.3 addresses requests for reinstatement involving "Dismissals for Failure to Comply with Board Procedures":

> Upon written motion *demonstrating good cause*, the Board may reinstate a case dismissed for failure to comply with Board procedures. Generally, *administrative oversight*, settlement negotiations or a change in representative *will **not** be considered good cause to reinstate*. If the dismissal was for failure to file with the Board a required position paper, Schedule of Providers, or other filing, the motion for reinstatement must, as a prerequisite, include the required filing before the Board will consider the motion.[5]

[3] Dismissal for Untimely Filing (Apr. 21, 2020).
[4] Providers' Motion for Reconsideration, at 1 (May 28, 2020).
[5] *See also* Board Rule 5.2 (stating "Failure of a representative to carry out his or her responsibilities is not

SunStone has attempted to frame the issue here as a situation where the late filing was the result of confusion amongst transfers and companion cases and where there sufficient other equitable justifications to overlook the late filing of the PPP. The following is a summary of SunStone's arguments and allegations in the reconsideration request:

1. SunStone alleges that the Board's dismissal is connected with an alleged "CMS directive for the Board to clear the backlog of cases and hold strict adherence to their rules." SunStone then alleges that, notwithstanding, the Board has great latitude because "there are many cases where the Board has allowed the providers to continue the pursuit of appeals, some of which date back to cost report years ending in the late 1990's."

2. SunStone alleges that Board Rule 47.3 "suggests that inclusion of the missing [PPP with a request for reinstatement] will be a dominant factor in deciding to reinstate" and, in support references its "knowledge" of another case where a provider had requested reinstatement that "[i]n a later motion to reconsider the dismissal of this appeal, the Board noted that had the preliminary position paper been filed with the original request for reinstatement it could have been accepted."

3. SunStone asserts confusion surrounding the transfers of some of the providers into the group created a "broad level of confusion" and should excuse the late filing of the PPP.

4. SunStone alleges that the PPP filed in the individual appeals should follow the provider when they transferred into the group appeal and otherwise obviated the need to file a PPP in the group appeal by the December 23, 2019 deadline. In support, SunStone alleges "all of the Hospitals that began the appeal as individual hospitals filed preliminary position papers [in the individual appeals] before the original due date of October 1, 2018 [for the filling of the PPP in the individual appeals] and that "[i]t was not until after those [PPPs in the individual cases were filed] that the Board recommended the individual appeals be consolidated into a group appeal." Further, SunStone asserts that outside of the amount in controversy, these PPPs are identical.

5. SunStone essentially asserts that the required PPP should not matter or is moot because of the nature of the appeal and that this appeal is somehow unique such that a PPP is not required. SunStone then implies that expedited judicial review in this case would be warranted because "[u]ltimately the Board will not have jurisdiction to settle this appeal and that is evidenced by the movement of identical appeals within the district court and court of appeals." In further support, SunStone notes that the Board has sent notice of "their intent . . . to file a motion for their own Expedited Judicial Review ("EJR") in at least 8 other appeals for FFYs 2018 and 2019." SunStone then notes that, in two other unidentified unrelated cases involving the same issue, the Board stated that it was considering giving notice of a potential own motion EJR and claims that "the Board is acknowledging that they do not have jurisdiction to rule on these six appeals and that *they have decided to move them forward* through the court system."[6]

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considered by the Board to be good cause for failing to meet any deadlines").
[6] (Emphasis added.)

6. Notwithstanding the late filing of the PPP, there are equitable considerations to justify continuation of these cases, namely that "the issue is having a significant impact on the payments to the hospitals" and "impacts all hospitals in the nations." As a result, SunStone asserts that "to exclude these hospitals because of an administrative error is not fair" and that the Providers "are equally as entitled to settlement of these issues as any other."

At the outset, the Board notes that SunStone misconstrues Board Rule 47.3. As the Rule makes clear, "if the dismissal was for failure to file with the Board a required position paper, . . . the motion for reinstatement must, *as a prerequisite*, include the required filing before the Board will consider the motion." As a result, the filing the missing/late position paper is merely a *prerequisite* to the Board reaching consideration of the merits of any request for reinstatement due to dismissal for failure to file a position paper (*i.e.*, in these circumstances, the Board would summarily reject a reinstatement request, without considering any merits, if the requisite missing position paper filing is not attached to the reinstatement request).[7] Accordingly, SunStone's filing of the missing/late PPP for the group simply means the Board may otherwise consider the *merits* of SunStone's request for reconsideration under Board Rule 47.3.

Similarly, the Board rejects Sunstone's suggestion that the Board dismissed the group appeal due to an alleged "CMS directive for the Board to clear the backlog of cases and hold strict adherence to their rules." There is no such CMS directive as the Board is responsible for setting its own process and procedure within the frame work of its governing statute and regulations.[8] Rather, the record is clear that SunStone simply failed to timely file the PPP for the group prior to the December 23, 2019 deadline *set by the Board* in the Critical Due Dates Notice issued on November 6, 2018. In this Notice, the Board expressly warned Sunstone that it "must meet the . . . due date[] regardless of any outstanding jurisdictional challenges, motions, or subpoena requests" and that "[i]f the Group misses any of its due dates, the Board ***will dismiss*** the appeal."[9] This is consistent with the guidance in the Board Rules as discussed more thoroughly in the April 21, 2020 dismissal. As such, SunStone was clearly on notice that it risked dismissal if it failed to timely file the group's PPP (which also requires service to the MAC and FSS).

The Board has reviewed the record in this case, including the *merits* of the subject Reconsideration Request, and finds that it did not err in its previous decision to dismiss this appeal pursuant to Board Rule 47.3 and 42 C.F.R. § 405.1868(b). SunStone provides no

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[7] SunStone claims "knowledge" of a Board ruling on reinstatement in an unrelated matter but fails to identify or provide a copy of that Board ruling. The Board is not aware of such a ruling *as characterized* by SunStone and disagrees with SunStone's characterization of Board Rule 47.3. Without a copy of the alleged Board ruling, the Board cannot place the ruling in the proper context of the facts and circumstances of that case and Board Rule 47.3.

[8] The Board sets its own process and procedure to manage its docket. *See* 42 C.F.R. § 405.1868(a) (stating: "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 conduct during proceedings in the appeal."); 42 C.F.R. § 405.1868(b) (stating: "If a provider failes 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 . . . .").

[9] (Emphasis added.)

explanation for its late filing beyond administrative error. As thoroughly explained in the Board's April 21, 2020 dismissal, administrative error is insufficient for the Board to reinstate the appeal under Rule 47.3. Instead, notwithstanding its administrative error, SunStone attempts to justify reinstatement based on certain allegations of generalized confusion and certain equitable considerations. As set forth below, the Board rejects SunStone's contentions and reaffirms the dismissal of the group appeal.

SunStone mischaracterizes the record and misstates facts. First, contrary to SunStone's allegations, the record does not reflect any confusion on the part of SunStone relating to the filing of the PPP for the group other than confusion or administrative error of its own making.[10] SunStone refers to the Board's decision to affirm the transfer of the five participants in this case to the optional group appeal based on the Board's finding that "it is understandable that there may have been some confusion in transferring these providers to the group appeal using a 'direct add' function [in then-newly implemented electronic filing system known as OH CDMS] rather than the transfer function." However, any confusion on how to effectuate a transfer cannot be conflated with the need to submit a Board-required filing by a specified deadline.[11] The electronic filing system is voluntary in nature and did not change the Board Rules for *when* to make filings (*e.g.*, position papers) but merely provided a new optional electronic means for submitting filings. There is no evidence that in the record that the availability of the new electronic filing system contributed to SunStone's failure to file the group's PPP by the December 23, 2019 filing deadline (which incidentally tolled more than a year after the October 24, 2018 transfers).[12] Indeed, the Critical Due Dates Notice was quite clear that the filing of the PPP was required for the group and that the Board would dismiss the group if the PPP was not timely filed by the deadline.

Further, contrary to SunStone's allegations, there is nothing in the record to suggest that the Board recommended that SunStone itself form its own optional group for the five providers that it was otherwise served as the designated representative in individual cases. In two of the individual cases (Case Nos. 18-0755 and 18-0910), SunStone requested postponement of the

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[10] For example, as the Board stated in the April 21, 2020 dismissal: "[T}the fact that the Representative had other cases (at least some of which involve different Providers) pending before the Board for this issue does not obviate the Representative's obligation to file the PPP in this case on behalf of these Providers. As Board Rule 5.2 states, '[t]he case representative is . . . responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party' and 'failure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines.' Further, it is unclear where the Representative's confusion arose as this was the only case in which it had a PPP filing due and the Critical Due Dates Notice made it clear that failure to timely file the PPP would result in dismissal."

[11] It is important to note that, while SunStone filed the transfers on October 24, 2018 using the incorrect electronic process (*i.e.*, as a direct add rather than a transfer), SunStone did not act thereafter with any confusion. Rather, SunStone proceeded as if the transfers were proper submitted as evidenced by the fact that, shortly after filing the transfers, SunStone filed withdrawal for four of the five individual cases (Case Nos. Case Nos. 18-0755, 18-0856, 18-0859, and 18-0910) in December 2018 and early January 2019 and noted therein that the sole issue in the case had been transferred to this group. Within days, the Board effectuated the withdrawals and closed the cases.

[12] If the optional electronic filing system was a factor, the Board would have expected SunStone to have mentioned it in the January 2020 request that the Board accept the late PPP. However, SunStone did not. Rather, Sunstone admits administrative error by apparently confusing the PPP deadline for this case with that in other appeals in which was the representative. *See supra* note 10; Board Dismissal dated Apr. 21, 2020 (for more thorough discussion).

preliminary position papers that were due to be filed in those cases on October 1, 2018. Specifically, in each case, SunStone requested abeyance "until a final decision has been rendered in the numerous group appeals pending before the . . . Board" for the same issue. The Board denied abeyance noting that the filing was still due on October 1, 2018 and that "*[i]f the Provider does not want to pursue its appeal of the issue* ***in its individual appeal***, it should request to participate in one of the many group appeals it mentioned in its request." Instead, of joining other ***existing*** group appeals mentioned in its correspondence, SunStone opted to form its own optional group appeal for the five providers which are not related by common ownership. In so doing, Board Rule 5.2 explains that, as the group representative, SunStone is "responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board or the opposing party" and "[f]ailure of a representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines."

Second, contrary to SunStone's assertion, any position papers filed in an individual appeal do not and cannot "transfer" to a group appeal to substitute for the group's obligation to file a PPP; Board Rules do not permit this.[13] Further, contrary to SunStone's allegation, the Board's review of the record in the five individual cases shows that only three of the five providers filed PPPs in their respective individual appeal (Case Nos. 18-0856, 18-0859, and 18-0860) prior to transferring to this group appeal.[14] The Critical Due Dates Notice was clear that the group had to file its PPP with the Board by the deadline. Had SunStone wished to use the arguments that it submitted in one or more of the position papers filed in the individual appeals, then SunStone should have filed a position paper with those arguments in the group appeal and served the MAC and FSS with a copy of that filing so that the MAC/FFS could respond and file its own position paper for the group. Of course, SunStone also had the option of expanding on or making new legal arguments in its briefing of the issue *for the group appeal*. Further, the fact that there are other pending but separate appeals (*i.e.*, not consolidated) before the Board (or in court) that have the same issue is irrelevant because each such appeal is separate and unique, *i.e.*, each such appeal is obligated to present its case/legal arguments to the Board and, in so doing, may make different arguments and/or present different evidence that ultimately may impact whether the appeal is successful. Accordingly, it was SunStone's responsibility as group representative to manage its case and to file the position paper and make determinations whether that filing is "complete . . . with a fully developed narrative . . . [and] all exhibits."[15]

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[13] The Board further notes that SunStone's desired view of Board procedure would just simply not be practical for a myriad of reasons, particularly since ***optional*** groups can involve tens to hundreds of ***unrelated*** providers and the designated representatives in an individual case is often different from the representative in group case.

[14] Indeed, as a result of the new allegations contained in the request for reconsideration relating to the individual appeals, the Board reviewed the record in the five individual appeals and discovered facts not considered in its original dismissal. The record reflects that: (1) the providers in Case Nos. 18-0755 and 18-0910 were required to file their preliminary position paper in the individual appeal by October 1, 2018; and (2) SunStone failed to make that filing prior to transferring these two providers to the group appeal on October 24, 2018. As such, even if the Board were to reinstate the group appeal (which it declines to do), the Board would have a separate and independent basis to dismiss the providers transferring from Case Nos. 18-0755 and 18-0910.

[15] Board Rule 25.3.

Finally, the fact that the Board may have later granted EJR for the issue in the group appeal (or has planned to issue or has issued notice of own motion EJR for the same issue in other appeals) is irrelevant. 42 C.F.R. § 405.1842(a)(1) addresses EJR and explains that the provider has a "right to seek" EJR or that the Board may consider EJR on its own motion:

> (a) *Basis and Scope*
>
> (1) This section implements provisions in section 1878(f)(1) of the Act that give a provider **the right to seek EJR** of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider **may request** a Board decision that the provider is entitled to seek EJR **or** t**he Board may consider** issuing a decision **on its own motion**. Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).[16]

Board Rule 42.1 addresses EJR and states: "A provider or group of providers may bypass the Board's hearing process and obtain expedited judicial review ("EJR") for a final determination of reimbursement that involves a challenge to the validity of a statute, regulation, or CMS ruling." If SunStone wished to "bypass the Board's hearing process" and not file position papers, then SunStone had the option of exercising its "right to seek" EJR prior to the deadline for filing the PPP but SunStone did not exercise that option.[17]

The Board recognizes that it may consider EJR on its own motion (*i.e.*, own motion EJR). However, it has not done so in this group case and is not obligated to do so. Further, there are no time constraints on making such a consideration. In this regard, the Board notes that, if a party itself does not file a request for EJR in a case, the Board often does not consider issuing a notice of own motion EJR until after the parties have filed their position papers (*i.e.*, when the parties legal arguments are fully developed) and the case has been set for hearing.[18] Further, when the Board issues a notice of own motion EJR, it is not a forgone conclusion that the Board will grant

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[16] (Bold and underline emphasis added.)
[17] *See also* April 21, 2020 dismissal (discussing options such as requesting consolidation with other cases that were available to SunStone that SunStone did not pursue prior to the PPP filing deadline).
[18] Significantly a pre-requisite to granting EJR is Board jurisdiction over the issue itself. As part of the position paper process, the parties may address jurisdictional impediments. *See* Board Rule 25.1.2(A). For example, there could be a question about the Board substantive jurisdiction over an issue, in whole or in part, if there is a statutory provision that may potentially bar administrative/judicial review of that issue, in whole or in part.

EJR or that the full scope and nature of the potential EJR has been set forth by the provider in the record.[19] Rather, in those instances, the Board requests comments from the parties on the appropriateness of EJR, including but not limited to defining or refining the scope and nature of the potential EJR itself if the Board were to ultimately grant EJR.

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In summary, the Board hereby denies the request for reconsideration and reaffirms its prior decision to dismiss pursuant to Board Rule 47.3 and 42 C.F.R. § 405.1868(b). The above rationale ***supplements*** the original April 21, 2020 dismissal. The Board's denial of the request for reconsideration is consistent with numerous cases in which federal courts have upheld the Board's authority to dismiss cases for failure of the provider to timely file position papers or other Board filings.[20] Accordingly, the Board hereby declines to reverse its original dismissal and the case remains closed.

Board Members Participating:

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

For the Board:

1/4/2021

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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[19] For example, the provider may clarify that it is not challenging the substantive and/or procedural validity of a rulemaking or regulation but rather is contesting how that rulemaking or regulation is interpreted and applied. Similarly, the provider could request the Board to hold a hearing to develop the underlying facts and record prior to the Board granting EJR as was done in the Board decision that led to the *Baystate* decision and the issuance of CMS Ruling 1498-R. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006).

[20] *Kaiser Found. Hosps. v. Sebelius*, 649 F.3d 1153 (9th Cir. 2011) (upholding dismissal for failure to file preliminary position paper); *Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226 (2009) (upholding dismissal for failure to file preliminary position paper); *High Country Home Health Inc. v. Thompson*, 359 F.3d 1307 (10th Cir. 2004); *Inova Alexandria Hosp. v. Shalala*, 244 F.3d 342, 351 (4th Cir. 2001) (upholding dismissal for failure to file preliminary or final position papers and stating "The Hospital argues that the Board irrationally concluded that administrative oversight is not a valid excuse. We disagree. Because the Hospital's failure to file timely position papers was due to circumstances entirely within its own control, the Board had a rational basis for its decision."); *UHI, Inc. v. Thompson*, 250 F.3d (6th Cir. 2001); *Lutheran Med. Ctr. v. Burwell*, No. 14-VC-731, 2016 WL 3882896 (E.D. N.Y. July 13, 2016); *Rapid City Reg. Hosp. v. Sebelius*, 681 F. Supp. 2d 56 (D.D.C. 2010) (upholding dismissal for failure to file preliminary position paper and citing to "the general proposition that legitimate procedural rules can be relied upon to control the Board's docket by dismissing appeals that are not timely filed" (citations omitted) and upholding Board's refusal to consider a motion for reinstatement that was improperly submitted by facsimile rather than properly filing by mail); *S.C. San Antonio Inc. v. Leavitt*, No. SA-07-CA-527-OG, 2008 WL 4816611(W.D. Tex. Sept. 30, 2008); *Lutheran Med. Ctr. v. Thompson*, No. 02-CV-6144, 2006 WL 2853870 (E.D. N.Y. Oct. 2, 2006); *Novacare, Inc. v. Thompson*, 357 F. Supp. 2d 268, 272-273 (D.D.C. 2005) (upholding denial of reinstatement where the Board explained that "failure to communicate clearly with its counsel was insufficient basis to justify reinstatement"); *Saint Joseph Hosp. v. Shalala*, No. 99-C7775, 2000 WL 1847976 (N.D. Ill. Dec. 15, 2000).

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

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

Palmetto GBA c/o National Government Services
Laurie Polson
Appeals Lead
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Jurisdictional Determination***
Novant 1998, 2000, and 2005-2006 DSH Medicaid Eligible Days Groups
FYEs 1998, 2000, and 2005-2006
Case Nos. 08-2559GC, 08-2570GC, 08-2581GC

Dear Mr. Ravindran and Ms. Polson,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced common issue related party ("CIRP") group appeals for Novant Health ("Novant"). The Board's jurisdictional decision is set forth below.

Background

A. Background on Case No. 08-2559GC

On August 6, 2008, the Group Representative filed a Request for Establishment of Mandatory Group Appeal and Request to Add and Transfer the Issue from Individual Appeals to Group Appeal for the Novant CIRP group named Novant 1998 DSH/Medicaid Eligible Days Group Appeal.[1] The Group Representative sought transfer of the following two Novant providers to this CIRP group:

1. Forsyth Memorial Hospital ("Forsyth"), Prov. No. 34-0014, FYE 12/31/1998, transferring from Case No. 05-0609; and

2. Presbyterian Hospital ("Presbyterian"), Prov. No. 34-0053, FYE 12/31/1998, transferring from Case No. 03-0443.

On August 19, 2008, the Board acknowledged the CIRP group appeal and assigned it to Case No. 08-2559GC. According to the latest Schedule of Providers submitted with the Group's Final

[1] Medicare Contractor's jurisdictional challenge in Case No. 08-2559GC, Exhibit C-1.

Position Paper received October 19, 2020, Forsyth and Presbyterian remain the *sole* participating providers in the Group.[2]

Pursuant to a Partial Administrative Resolution for this CIRP group executed on October 13, 2016, the parties agreed to: (a) fully resolve the appeal by Forsyth; and (b) partially resolve the appeal by Presbyterian leaving only the alleged "sub-issue"3 regarding adolescent psychiatric unit days unresolved. Both the Medicare Contractor and the Group Representative agreed that the remaining unresolved DSH "sub-issue" for Presbyterian would be held in abeyance and governed by the decisions in Presbyterian Hospital's FYE 12/31/2001 appeal under Case No. 06-1851 and FYE 12/31/2002 appeal under Case No. 06-1852.[4]

B. Background on Case No. 08-2570GC

On August 6, 2008, the Group Representative filed a Request for Establishment of Mandatory Group Appeal and Request to Add and Transfer the Issue from Individual Appeals to Group Appeal for the Novant CIRP group named the Novant 2000 DSH/Medicaid Eligible Days Group Appeal.[5] The Group Representative sought transfer of the following three providers into the CIRP group:

1. Forsyth Memorial Hospital ("Forsyth"), Prov. No. 34-0014, FYE 12/31/2000 transferring from Case No. 03-0443;

2. Presbyterian Hospital ("Presbyterian"), Prov. No. 34-0053, FYE 12/31/2000, transferring from Case No. 05-0612; and

3. Thomasville Medical Center ("Thomasville"), Prov. No. 34-0085, FYE 12/31/2000, transferring from Case No. 05-0725.

The Board acknowledged the CIRP group appeal and assigned it to Case No. 08-2570GC.

On February 3, 2011, the Group Representative withdrew Thomasville from the CIRP group.[6] On October 25, 2011, the Group Representative withdrew Forsyth as Forsyth's issue had been

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[2] Medicare Contractor's jurisdictional challenge in Case No. 08-2559GC, Exhibit C-2.
[3] As discussed later in this determination, there can only be one question of fact or law in a group and that question must be *common* to ***all*** providers in the group. As such, a group necessarily should not contain any "sub-issues" unique to only one provider in the group as such a "sub-issue" would necessarily involve questions of fact and/or law unique to that sole provider. Accordingly, what the Parties describe as a "sub-issue" in the CIRP groups necessarily raises questions about whether that "sub-issue" is properly part of those CIRP groups and is subject to dismissal. Due to these questions, the Board refers to the Presbyterian adolescent psychiatric unit days issue as the "alleged 'sub-issue.'"
[4] Medicare Contractor's jurisdictional challenge in Case No. 08-2559GC, Exhibit C-4.
[5] Medicare Contractor's jurisdictional challenge in Case No. 08-2570GC, Exhibit C-1.
[6] Medicare Contractor's jurisdictional challenge in Case No. 08-2570GC, Exhibit C-2.

fully resolved pursuant to a Partial Mediation Agreement.[7] Accordingly, the sole participant remaining in the CIRP group is Presbyterian.

Pursuant to a Partial Administrative Resolution executed on March 16, 2017, the parties agreed to partially resolve the appeal by Presbyterian Hospital leaving only the alleged "sub-issue" regarding adolescent psychiatric unit days unresolved. Both the Medicare Contractor and the group appeal Representative agreed that the alleged remaining unresolved DSH "sub-issue" for Presbyterian would be held in abeyance pending the Board ruling in Presbyterian Hospital's FYE 12/31/2001 appeal under Case No. 06-1851 and FYE 12/31/2002 appeal under Case No. 06-1852.[8]

C. Background on Case No. 08-2581GC

On August 8, 2008, the Group Representative filed a Request for Establishment of Mandatory Group Appeal and Request to Add and Transfer the Issue from Individual Appeals to Group Appeal for the Novant CIRP group named the Novant 2005-2006 DSH/Medicaid Eligible Days Group Appeal.[9] The Group Representative sought transfer of the following two providers into this CIRP group:

1. Forsyth Medical Center ("Forsyth"), Prov. No. 34-0014, FYE 12/31/2005, transferring from Case No. 08-1322; and

2. Presbyterian Hospital ("Presbyterian"), Prov. No. 34-0053, FYE 12/31/2005, transferring from Case No. 08-1158.

The Board acknowledged the CIRP group appeal and assigned it to Case No. 08-2581GC.

On June 25, 2010, the Group's Representative submitted a Request to Expand Years and Transfer to include Forsyth for its FYE 12/31/2006 for the CIRP group's common issue by transferring Forsyth from Case No. 10-0150.[10] Similarly, on December 9, 2010, the Group's Representative submitted a Request to Transfer Presbyterian for its FYE December 31, 2006 into the CIRP group from Case No. 10-1030.[11]

Pursuant to a Partial Administrative Resolution executed on March 24, 2017, the parties agreed that: (1) Forsyth would withdraw its appeal for FYE 12/31/2005; (2) Forsyth's appeal for FYE 12/31/2006 would be fully resolved; and (3) the appeals for Presbyterian for FYE 12/31/2005 and 12/31/2006 would be partially resolved leaving only the alleged "sub-issue" regarding adolescent psychiatric unit days unresolved for both FYE 12/31/2005 and 12/31/2006. With regard to Presbyterian, the parties stipulated that the "sub-issue" of whether inpatient days in the

[7] Medicare Contractor's jurisdictional challenge in Case No. 08-2570GC, Exhibit C-3.
[8] Medicare Contractor's jurisdictional challenge in Case No. 08-2570GC, Exhibit C-5.
[9] Medicare Contractor's jurisdictional challenge in Case No. 08-2581GC, Exhibit C-1.
[10] Medicare Contractor's jurisdictional challenge in Case No. 08-2581GC, Exhibit C-3.
[11] Medicare Contractor's jurisdictional challenge in Case No. 08-2581GC, Exhibit C-4.

adolescent psychiatric unit should be counted and included in the DSH calculation will be held in abeyance pending the Board ruling in the Presbyterian appeals pending in Case Nos. 06-1851 and 06-1852.[12]

D. Background Information Common to Each CIRP Group Appeal

All three Novant CIRP groups presented the *common* issue statement for the group as:

> The Providers contend that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, the Providers disagree with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's regulations. The Intermediary, contrary to the regulation, failed to include as Medicaid eligible days services to all patients eligible for Medicaid.[13]

The Medicare Contractor contends that the CIRP groups abandoned Presbyterian's alleged "sub-issue" for Medicaid eligible days for the adolescent psychiatric unit when the Group Representative failed to brief the issue in their Final Position Papers or provide ***any*** supporting documentation to demonstrate that the Medicare Contactor's computation was improper relative to that alleged "sub-issue." The Medicare Contractor contends that the Board should consider the appeals withdrawn and close the cases because Presbyterian's allged "sub-issue" of Medicaid eligible adolescent psychiatric unit days is the sole remaining issue in the CIRP group appeals.

The Medicare Contractor notes that Presbyterian filed substantially similar appeals for FYEs December 31, 2001 and December 31, 2002 in Case Nos. 06-1851 and 06-1852, respectively. In those two ***individual*** cases, Presbyterian appealed the issue of Medicaid eligible days and raised the sub-issue regarding adolescent psychiatric days. The appeals were consolidated, and a hearing took place on September 25, 2015.

On November 27, 2017, the Board issued its decision in the consolidated individual appeals in Case Nos. 06-1851 and 08-1652 finding that it did not have jurisdiction under 42 U.S.C. § 1395oo(a) over the Medicaid adolescent psychiatric days at issue for FYs 2001 and 2002. The Board declined to exercise its discretion under 42 U.S.C. § 1395oo(d) to consider the issue on the merits and dismissed both of the individual appeals.

On October 19, 2020, the CIRP groups submitted their Final Position Papers via OHCDMS. In their Final Position Paper, the Groups failed to brief the alleged "sub-issue" of the Medicaid eligible days for the adolescent psychiatric unit. In fact, the Final Position Papers submitted by

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[12] Medicare Contractor's jurisdictional challenge in Case No. 08-2581GC, Exhibit C-6.
[13] Medicare Contractor's jurisdictional challenges in Case Nos. 08-2559GC, 08-2570GC and 08-2581GC, Exhibit C-1.

the CIRP Groups on October 19, 2020 are almost identical to the Groups' previously submitted Final Position Papers.[14]

Neither the previously-submitted Final Position Papers ***nor*** the October 19, 2020 Final Position Papers specifically addresses the alleged "sub-issue" related to the adolescent psychiatric days. In addition, the Groups' Final Position Papers fail to even address the Partial Administrative Resolutions in the appeals or the terms of those agreements.

The Medicare Contractor submitted substantially similar jurisdictional challenges in the appeals on November 19, 2020. The Providers did not submit jurisdictional responsive briefs.

Medicare Contractor's Position

The Medicare Contractor contends that three Novant CIRP groups effectively abandoned the alleged sole remaining "sub-issue" in their appeals, *i.e.*, the DSH Medicaid Eligible Days for the Adolescent Psychiatric Unit of Presbyterian Hospital, when they failed to brief the alleged "sub-issue" issue in their final position papers submitted on October 19, 2020. Specifically, the Medicare Contractor contends that the Group Representative failed to state the material facts that support their claims that the Medicare Contractor failed to include the disputed adolescent psychiatric days in the DSH calculation Presbyterian and failed to identify or produce any documents explaining or demonstrating that those Medicaid eligible days should have been included in Presbyterian's DSH calculation. The Medicare Contractor contends that the Groups' Final Position Papers clearly failed to meet the requirements set forth in Board Rule 25.1.1.

The Medicare Contractor points to the Board's jurisdictional decision in Lakeland Regional Health, Case No. 13-2953, when the Board found that the provider abandoned its appeal in its final position paper when it failed to develop arguments, set forth the merits of its claim, or explain why it disputed the relevant calculations. The Medicare Contractor argues that this jurisdictional decision is relevant to the instant appeals. The Groups' final position papers are devoid of material facts, supporting documents or analysis regarding Presbyterian's disputed Medicaid eligible adolescent psychiatric days. Accordingly, the Medicare Contractor maintains that Board should find that the Groups effectively abandoned the alleged "sub-issue" related to Medicaid eligible psychiatric days.

The Medicare Contractor notes that, with respect to Case No. 08-2559GC, the Group also failed to reference the Partial Administrative Resolution and the fact that the appeal related to Forsyth was fully resolved. With respect to Case Nos. 08-2570GC and 08-2581GC, the Groups also failed to reference the Partial Administrative Resolutions and the terms of those agreements which resolved all issues except for the alleged matter related to Presbyterian's Medicaid eligible psychiatric unit days.

[14] Final Position Papers were previously submitted as follows: September 18, 2015 for Case No. 08-2559GC, July 22, 2011 for Case No. 08-2570GC and August 21, 2015 for Case No. 08-2581GC.

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.

At the outset, the Board notes that, pursuant to 42 C.F.R. § 405.1837(a), a provider has "a right to a Board hearing, as part of a group appeal with other providers if . . . [t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." To this end, 42 C.F.R. § 405.1837(c) specifies that the group appeal request to establish a group appeal must include "a precise description of ***the one*** fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal." Similarly, 42 C.F.R. § 405.1837(f)(2) specifies that "[t]he Board may not consider, in one group appeal, more than ***one*** question of fact, interpretation of law, regulations, or CMS Ruling *that is common to* ***each*** *provider*."[15]

Based on these regulations, it is clear that a group necessarily should not contain any "sub-issues" unique to only one provider in the group and, in particular, that a self-described "sub-issue" for one provider in a group necessarily would involve questions of fact and/or law unique to that provider. Accordingly, it is clear the alleged "sub-issue" in these CIRP groups involving Presbyterian's adolescent psychiatric units involves issues of fact and law not common to the other providers in the group and may be subject to dismissal[16, 17] (and any administrative resolution agreement between the Parties cannot change or waive this fact[18]). However, the Board need not rule on that because, as explained below, the Group Representative has abandoned the alleged "sub-issue" and, as a result, those other potential bases for dismissal are rendered moot.

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

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[15] (Emphasis added.)

[16] The unique nature of the adolescent psychiatric unit days issue is made abundantly clear in the following Board decision and associated Administrator remand decision addressing the inclusion of adolescent psychiatric unit days in the Medicaid fraction of the DSH calculation: *St. Anthony Hosp. v. Novitas Solutions, Inc.*, PRRB Dec. No. 2018-D12 (Dec. 28, 2017), *vacated and remanded by*, Adm'r dec. (Mar. 6, 2018). *See also* the Board jurisdiction decision in the consolidated Presbyterian appeals of this issue under Case Nos. 06-1851 and 08-1652 wherein the Board determined that it lacked jurisdiction over Presbyterian's appeal of this issue.

[17] Moreover, the basis for the Board's ruling that it lacked jurisdiction over Presbyterian's adolescent psychiatric days issue in Case Nos. 06-1851 and 08-1652 could potentially be applicable here. However, the Board need not review the record to determine this since the Group Representative's abandonment of the alleged "sub-issue" renders it moot.

[18] Board Rule 4.1 makes clear that "[t]he parties cannot waive jurisdictional requirements."

> 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.[19]

Board Rule 27 incorporates the requirements for preliminary position papers as delineated in Board Rule 25. In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> 27.2 Content
>
> The final position paper should address each remaining issue. *The minimum requirements* for the position paper narrative and exhibits *are the same as those outlined for preliminary position papers at Rule 25*.[20]
>
> **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*.
>
> 25.2 Position Paper Exhibits
>
> 25.2.2 Unavailable and Omitted Documents

[19] (Italics emphasis added.)
[20] (Italics emphasis added.)

> *If documents necessary to support your position are still unavailable*, identify the missing documents, *explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available*. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

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 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 Board finds that the Providers in the instant group appeals abandoned the sole remaining alleged "sub-issue" in their appeals, DSH Medicaid Eligible Days for the Adolescent Psychiatric Unit of Presbyterian Hospital, when they failed to brief the issue in their final position papers submitted on October 19, 2020. The regulation at 42 C.F.R. § 405.1853(b)(2), as well as Board Rules 25 and 27, make it clear that Final Position Papers must address ***each*** remaining issue in the appeal. As Board Rule 25.3, "Parties should file a **complete** . . . position paper with a fully developed narrative . . . [and] all exhibits." As such, the Board concludes that the Group Representative abandoned any alleged "sub-issue" involving the Presbyterian adolescent psychiatric unit and dismisses it from the appeal.[22] As no issues remain in the CIRP group appeals, the Board hereby dismisses them and removes them from the Board's docket.

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[21] (Italics emphasis added.)

[22] The Board's decisions in other cases involving adolescent psychiatric unit days highlights the complex nature of both facts and legal issues surrounding the potential inclusion of these days in the Medicaid fraction of the DSH calculation and the need of both Parties to fully address and brief in their position papers the legal arguments ***and*** facts (including exhibits) on the issue. *See supra* note 16 (referencing prior Board decisions on adolescent psychiatric unit days).

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:

1/6/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

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

Dylan Chinea
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520-2546

RE: ***Expedited Judicial Review Determination***
Sutter Health CY 2005 DSH SSI Ratio Dual Eligible Part C Days CIRP Group
FYEs 12/31/2005
Case No. 19-0158GC

Dear Mr. Chinea:

The above-referenced common issue related party ("CIRP") group appeal[1] 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 December 11, 2020, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

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

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] 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

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

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Provider's Request for EJR

The Providers within this CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2005 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after this CIRP group was established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

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[30] *Id*. at 14.
[31] *Id*. at 17.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR request filed appeals of either original Notices of Program Reimbursement ("NPRs") or revised NPRs ("RNPRs") in which the Medicare contractor settled cost reporting periods ending in 2005.

For Providers with appeals filed from original NPRs for cost reporting periods ending before December 31, 2008, the Providers may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[34]

For Providers with appeals filed from RNPRs issued after August 21, 2008, the Board only has jurisdiction to hear a provider's appeal of matters that the Medicare contractor specifically revised within the RNPR.[35]

Individual Provider Jurisdiction

Following review of the Schedule of Providers ("SOP") and associated jurisdictional documentation submitted for the instant group appeal,[36] the Board finds that each of the Providers timely filed individual appeal requests, that contain the Part C Days issue, from either original NPRs or RNPRs settling the 2005 cost reporting period, and that the amount in controversy for the group exceeds $50,000. The Board notes that the estimated amount in

[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] 485 U.S. at 399 (1988). Under the facts of *Bethesda*, the Board initially found that it was without jurisdiction to review the providers' challenge to the Secretary's regulation regarding apportionment of malpractice insurance costs because the providers had "self-disallowed" the costs in their respective cost reports filed with the Medicare contractor. The Supreme Court held that "[t]he Board may not decline to consider a provider's challenge to a regulation of the Secretary on the ground that the provider failed to contest the regulation's validity in the cost report submitted to [the Medicare Contractor]." The Court went on to state that "the submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations."
[35] *See* 42 C.F.R. § 405.1889(b)(1) (2008).
[36] The Board notes that, in the SOP and Jurisdictional Documentation submitted on May 15, 2020, the Providers mistakenly submitted the Notice of Cost Report Revision (dated January 9, 2017) instead of the RNPR (dated /January 11, 2017) for Provider Nos. 05-0714 and 05-0101. Both providers submitted the same documents in their respective individual appeals but submitted the corrected RNPRs pursuant to the Board's Request for Additional Documentation.

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

With respect to the dissatisfaction prong of the Board's jurisdictional analysis, the Board finds as follows. The six Providers, listed below, filed appeals from original NPRs and, thus, may demonstrate dissatisfaction with the amount of Medicare reimbursement of the Part C Days issue by claiming the issue as a "self-disallowed cost" pursuant to the Supreme Court's reasoning set out in *Bethesda*.[37] Indeed, they had to self-disallow as the regulation at issue mandated that Part C days be counted in the SSI fraction.

- Prov. No. 05-0305, Alta Bates Medical Center Berkeley;
- Prov. No. 05-0047, California Pacific Medical Center-Pacific;
- Prov. No. 05-0008, California Pacific Medical Center-Davies;
- Prov. No. 05-0043, Summit Medical Center;
- Prov. No. 05-0108, Sutter Medical Center-Sacramento; and
- Prov. No. 05-0291, Sutter Medical Center-Santa Rosa.

The four remaining Providers filed their respective appeals from RNPRs.[38] Within its November 6, 2020 Jurisdictional Challenge, the Medicare Contractor questioned the Board's jurisdiction to hear the appeals of the Part C Days issue for these four Providers. Specifically, the Medicare Contractor argues that the Part C Days issue was not adjusted in the "challenged" Providers' RNPRs.[39] The Medicare Contractor goes on to explain why these RNPRs were issued:

> The initial NPRs for the four challenged providers were revised *pursuant to CMS Ruling CMS 1498-R* and those providers take appeal from the resulting RNPRs. CMS Ruling 1498-R was implemented to address three specific issues related to the DSH SSI Percentage:
>
> 1. Data Matching Process—SSI Fraction only
> 2. Non-Covered and Benefit Exhausted Days—SSI Fraction [o]nly
> 3. Labor and Delivery Room Days—either SSI Fraction or Medicaid Fraction[40]
>
> . . . .
>
> [T]he scope of the RNPR adjustments at issue was limited to the items identified in CMS Ruling CMS-1498-R, and a review of the respective Adjustment Reports confirm that the specific item on

[37] *See supra* note 34.
[38] The providers are Memorial Hospital - Modesto (Prov. No. 05-0557); Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714); St. Luke's Hospital (Prov. No. 05-0055); and Sutter Solano Medical Center Vallejo (Prov. No. 05-0101).
[39] Nov. 6, 2020 Jurisdictional Challenge at 3.
[40] *See* Nov. 6, 2020 Jurisdictional Challenge Exhibits C-8.

> appeal was neither addressed nor specifically adjusted in the RNPRs for the four challenged providers.[41]

Based on its review of the jurisdictional documentation for these four providers, the Board notes that, following reopening of the cost reports pursuant to CMS 1498-R, the SSI percentage was revised for three of the Providers — Memorial Hospital - Modesto (Prov. No. 05-0557); St. Luke's Hospital (Prov. No. 05-0055); and Sutter Solano Medical Center Vallejo (Prov. No. 05-0101) — but remained unchanged for the fourth, Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714).

Accordingly, prior to joining the current group appeal based on their RNPR appeals, all four of these Providers had the opportunity to appeal and challenge various components or aspects of CMS' calculation of the SSI percentages *from their original NPR*. As noted in Board Rule 8.1 (July 1, 2015), "[s]ome issues may have multiple components" and "[t]o comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7."[42] This is recognized in CMS Ruling 1498-R ("1498-R") and it addressed only three components of the SSI fraction:

> The DSH payment adjustment has been the subject of substantial litigation. This Ruling addresses three recurring issues pertaining to the calculation of the DPP under section 1886(d)(5)(F)(vi) of the Act and § 412.106(b) of the regulations and the jurisdiction of the PRRB and the other administrative tribunals over appeals of these issues. (However, this Ruling does not address the increased Medicaid payments that are required by sections 1902(a)(13)(A)(iv) and 1923 of the Act (42 U.S.C. §§1396a(a)(13)(A)(iv), 1396r-4) for hospitals that serve a disproportionate number of low income patients with special needs.)

The three components, or issues, of the SSI fraction addressed by 1498-R and for which 1498-R "eliminate[d] any actual case or controversy" were:

1. "*[T]he Data Matching Process Used in Calculating the SSI Fraction*." The Ruling applied to then-pending appeals of this issue "challenging CMS's data matching process, which the agency uses in determining the SSI fraction by matching Medicare and SSI eligibility data." The seminal case dealing with this issue is *Baystate Medical Center v.*

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[41] *Id*. at 5; *see* Nov. 6, 2020 Jurisdictional Challenge Exhibits C-9 through C-16.

[42] This language in Board Rule 8.1 as existed since Aug. 21 , 2008 as confirmed by comparing the Board Rules issued on August 1, 2008, July 1, 2009, and March 1, 2013 (available at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions). This language emanated from the changes made in 2008 to 42 C.F.R. § 405.1835(a)-(b) to make clear that an appeal request must address each "specific item(s) at issue" including, *for **each** such item*: (a) demonstration that the provider satisfies the requirement for a Board hearing, (b) explanation of the provider's dissatisfaction, including why Medicare payment is incorrect and how and why payment should be determined differently *See* 73 Fed. Reg. 30190 (May 23, 2008).

Leavitt, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008). As a result, this issue is sometimes referred to as the *Baystate* SSI data matching issue.

2. "*[T]he Exclusion from the DPP [i.e., disproportionate share percentage] of Non-Covered Inpatient Hospital Days for Patients Entitled to Medicare Part A, and Days for Which the Patient's Part A Inpatient Hospital Benefits were Exhausted*." The Ruling applied to "cost reports with discharges before October 1, 2004" for which hospitals have pending "appeals seeking inclusion in the DPP of inpatient days where the patient was entitled to Medicare Part A but the inpatient hospital stay was not covered under Part A" (e.g., exhausted days and Medicare secondary payor ("MSP") days).

3. "*[T]he Exclusion from the DPP of Labor/Delivery Room ["LDR"] Inpatient Days.*" The Ruling applied to "cost reporting periods beginning before October 1, 2009" for which hospitals have pending appeals "seeking inclusion of LDR inpatient days in the DPP regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour."

Accordingly it is clear that: (1) each of these four Providers appealed from their original NPR for FYE 12/31/2005; (2) these original NPR appeals included at least the *Baystate* SSI data match issue; (3) these original NPR appeals did not include the SSI Medicare Part C days issue since these Providers are participating *in this CIRP group* based only on their RNPR appeal[43] and since Part C is separate issue from the *Baystate* data matching issue;[44] and (4) these four Providers were remanded pursuant to Ruling 1498-R for the *Baystate* SSI data matching issue since that was the only 1498-R issue applicable to FYE 12/31/2005.[45] These four Providers then later appealed from the RNPR issued following that 1498-R remand resulting in their participation in the present case, Case No. 19-0158GC.

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[43] Since the four Providers are commonly owned, it is clear that any appeal of the Part C days issue by these four Providers for 2005 needed to be part of this CIRP group appeal regardless of whether that appeal is based on an original NPR or an RNPR. In this regard, the Board notes that 42 C.F.R. § 405.1837(b)(1) states that "[t]wo or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must bring the appeal as a group appeal***." (Emphasis added.) To this end, § 405.1837(e)(1) states: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider*** under common ownership or control ***may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis added.) Further, even if they had previously appealed the Part C issue for 2005 but it was either withdrawn or dismissed, they would not be able to later appeal the exact same issue for the same year. *See* Board Rule 4.6.3, 41, 46.

[44] The data matching process issue (*see infra* note 46) challenges how the subset of a provider's universe of inpatient days used in the SSI fraction are identified and then gathered, while the Part C days issue challenges the regulation that mandates that any identified Part C days be counted in the SSI fraction. Neither the group issue statement in this CIRP group nor EJR request contest the data matching process itself (*e.g.*, claiming that there are Part C days missing from the SSI fractions at issue).

[45] Specifically, on December 10, 2015, the Board issued a standard 1498-R remand order for Case No. 09-1530GC, "Sutter Health 2005 DSH SSI Ratio CIRP Group" for the providers' "challenge to the data matching process in calculating the Supplemental Security Income (SSI) fraction." A copy of this remand order was attached to one or more of the transfer requests filed by the four Providers for Case No. 19-0158GC.

The Board notes that, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. Here, CMS specifically revised the Providers' SSI percentages based on data gathered under the new data matching process and then the Medicare Contractor used the new SSI fraction to recalculate Providers' DSH adjustments. As the data generated under the new data matching process includes Medicare Part C days,[46] the Board must assume that the updated SSI fraction issued for Memorial Hospital - Modesto (Prov. No. 05-0557); St. Luke's Hospital (Prov. No. 05-0055); and Sutter Solano Medical Center Vallejo (Prov. No. 05-0101) included changes to Part C days included therein.[47] Accordingly, the Board finds that the Part C Days issue was "specifically" revised as part of the RNPR for Memorial Hospital - Modesto (Prov. No. 05-0557); St. Luke's Hospital (Prov. No. 05-0055); and Sutter Solano Medical Center Vallejo (Prov. No. 05-0101). Further, per the 2014 holding of the D.C. Circuit in *Allina I*, Part C days necessarily ***must*** be included in either the SSI fraction or Medicaid fraction.[48] Accordingly, even though the Medicaid fraction was adjusted in the RNPR for these three Providers, the Board has jurisdiction over their demand to have the Medicare Part C days excluded from the SSI fraction and included in the Medicaid fraction of the DPP used to calculate their DSH adjustment.

With respect to the remaining provider, Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714), there was no adjustment or revision to its SSI percentage in the RNPR. Rather, the RNPR showed "0" difference or change. Accordingly, unlike the above three Providers, it is clear that there was no adjustment to the SSI fraction for the *Baystate* SSI data matching issue (*i.e.*, the issue that was remanded per Ruling 1498-R) and, as a result, there necessarily was no adjustment to Part C days in the SSI fraction.[49] If Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714) wished to appeal or contest the Part C days issue, it should have appealed that issue from its original NPR when it clearly had the right to do so since appeals of any potential future RNPRs is limited to matters "specifically revised."[50] In this regard, the Board

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[46] CMS describes the data 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 "days" data underlying a provider's SSI fraction is gathered on a month-by-month basis. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis).

[47] In other words, a by-product of CMS going through the new data matching process (*see supra* note 46) for each of these three Providers is that CMS generated new or revised "days" data that resulting in a revised or new SSI percentage. Unless there is evidence to the contrary (which there is not), the Board must assume that the updated "days" data resulting from the new data match process included revisions or changes to Part C days included in that data. The Providers are challenging the regulation promulgated in the August 11, 2004 final rule that requires these Part C days to be counted in the SSI fraction.

[48] Specifically, *Allina I* 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.

[49] Without a change to the SSI fraction, the Board must assume there were no changes to the underlying data used to calculate the SSI fraction. *See, in contrast, supra* note 47.

[50] For context, the Board takes administrative notice that:

1. The final rule establishing the Agency's current policy on treatment of Part C days in the SSI fraction (and the one at issue in this case) was issued on August 11, 2004 and the Agency's Part C days policy, both prior to and following the August 11, 2004 final rule, has been subject to much litigation. *See, e.g.*, *Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King*

notes that Ruling 1498-R did not apply to SSI Medicare Part C days issues and, thus, the SSI Medicare Part C Days issue was outside the scope of Ruling 1498-R.[51] The Board recognizes that Ruling 1498-R states the RNPR issued following a 1498-R remand ***of the Baystate SSI data matching issue*** "will be subject to administrative and judicial review in accordance with the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines." However, "the applicable jurisdictional and procedural requirements of . . . the Medicare regulations" includes 42 C.F.R. § 405.1889 and, as discussed above, this regulation limits Board jurisdiction to "those matters that are specifically revised." Here, it is clear that the Part C days issue was both outside the scope of 1498-R and not "specifically" revised in the RNPR at issue for Sutter Maternity & Surgery Center Santa Cruz.[52] Accordingly, the Board dismisses Sutter Maternity & Surgery Center Santa Cruz pursuant to Ruling 1498-R and 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1) and notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[53]

In conclusion, except for Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714), the Board finds that all providers listed within the SOP have shown that they have a right to a hearing before the Board under 42 C.F.R. § 405.1835(a).

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the*

& Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).

2. Most providers filing Board appeals of the Part C days issue have done so by appealing from their original NPR, regardless of whether that NPR was issued prior to or after 1498-R (including certain appeals filed pre-2010 in which the provider later requested bifurcation of the Part C days issue from dual eligible days issues emanating from the same August 11, 2004 final rule).

[51] *See* CMS Ruling 1498-R at 18 (stating: "[I]f the administrative tribunal finds that a given claim is outside the scope of the Ruling (because such claim is not for one of the three DSH issues) or the claim fails to meet the applicable jurisdictional and procedural requirements for relief under the Ruling, then the appeals tribunal will issue a written order, briefly explaining why the tribunal found that such claim is not subject to the Ruling. The appeals tribunal will then process the provider's original appeal of the same claim in accordance with the tribunal's usual, generally applicable appeal procedures.").

[52] Further, the Board notes that, if the issue in this appeal pertain to the *Baystate* data match issue (as opposed to the Part C days issue), the situation would be very different and the Board would have jurisdiction over it pursuant to Ruling 1498-R and 42 C.F.R. § 405.1889(b). In that scenario, while the provider's RNPR would have no adjustment, the provider would just trying to resume its original PRRB appeal of the *Baystate* SSI data match issue (which the Ruling had eliminated and required the Board to remand) and would be dissatisfied with the intervening application of a new data match process (as mandated by Ruling 1498-R) that did not change to its SSI fraction (*i.e*, it would be dissatisfied with the mandated new data matching process did not result in a change to its SSI fraction due to flaws in that new data matching process).

[53] *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).

Administrator.[54] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[55] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[56] To date, CMS has yet to issue its new final rule.[57]

As the Providers' appeals concern the FY 2005 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[58] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the

[54] (Emphasis added.)
[55] CMS Ruling 1739-R at 1-2.
[56] Id. at 2.
[57] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[58] (Emphasis added.)

> statute's grant of providers' substantive appeal rights and is invalid.[59]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[60] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[61]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of a CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [62] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[63]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or

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[59] EJR Request at 17.
[60] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).
[61] *See Southwest* at 6-7.
[62] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[63] *See* CMS 1739-R at 8.

procedural validity of a regulation or CMS Ruling.[64] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers, except for Sutter Maternity & Surgery Center Santa Cruz (Prov. No. 05-0714), contained within the instant group appeal;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the remaining Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the remaining Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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:

1/8/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Lorraine Frewert, Noridian Healthcare Solutions, Inc. c/o Cahaba Safeguard Administrators

[64] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

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

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

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
Hall Render CY 2010 DSH Part C Days Group
Case No. 20-0170G

Dear Ms. Griffin:

The above-referenced group 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 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 December 14, 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's decision to deny the request 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]

Providers' Request for EJR

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary's erroneous inclusion of inpatient days attributable to Medicare Advantage patients in both the numerator and the denominator of the of the Medicare fraction.

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

The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).[18]

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II.*[19]

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.[20]

With respect to EJR, the Providers maintain that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers conclude that the Board is without the authority to decide the legal question, therefore EJR is appropriate.[21]

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.

[18] Request for EJR at 2.
[19] *Id.*
[20] *Id.*
[21] *Id.* at 8. The Providers' EJR request was filed on December 14, 2020 but does not address Ruling 1739-R issued roughly 4 months earlier on August 17, 2020.

Pursuant to CMS Ruling 1739-R, the Board no longer has jurisdiction over appeals of this issue as of August 17, 2020 (*i.e*. as of the date of issuance of Ruling 1739-R) and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[22] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue as of August 17, 2020, 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 will be reviewing the group case 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.

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:

1/12/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Judith Cummings, CGS Administrators

[22] (Emphasis added.)

Appendix A

Model Form G: Schedule of Providers in Group

Case No: 20-0170G Date Prepared: 12/10/2020

Group Name: Hall Render CY 2010 DSH Part C Days

Group Representative: Hall, Render, Killian, Heath & Lyman, P.C.

Lead Intermediary: CGS Administrators, Inc-J15

Issue: DSH Part C Days

					A	B	C	D	E	F	G
Exhibit #	Provider Number	Provider Name / Location *(City, County, State)*	FYE	MAC	Date of Final Determination	Date of Hearing Request / Add Issue Request	No. of Days	Audit Adj. No.	Amount in Controversy	Prior Case No(s).	Date of Direct Add / Transfer(s) to Group
1	23-0037	Hillsdale Community Health Center *(Hillsdale, Hillsdale, MI)*	6/30/10	WPS-8	8/2/13	11/14/13	104	35, 36	$ 110,470	Individual 14-0762	11/14/13 5/7/2020
2	36-0051	Miami Valley Hospital *(Dayton, Montgomery, OH)*	12/31/10	CGS-15	5/1/19	10/28/19	180	4,8,21,23, 24,46	$ 1,184,321	Direct Add	10/28/19
3	49-0009	University of Virgina Med. Ctr. *(Charlottesville, Charlottesville, VA)*	6/30/10	Palmetto c/o NGS-M	12/28/18	4/18/19	111	4,37,38, 40,75	$ 525,868	Individual 19-1725	4/18/19 10/21/2019
		Total							**$ 1,820,659**		

4816-8767-5050

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 Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave., NW
Washington, DC 20006

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
Case Nos. 14-1693GC, 14-2739GC, 14-2740GC
FYE 6/30/2011

Dear Ms. Webster:

The three above-referenced common issue related party ("CIRP") group appeals[1] include 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 9, 2020, the Providers in the above-referenced CIRP group appeals filed requests for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.
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> 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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within these CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2010 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
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> . . . .
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> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Analysis and Decision

After review of the Providers' EJR Requests, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP groups and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

[30] *Id*. at 14.
[31] *Id*. at 17.

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2010.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R specifies that: "For such appeals, assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought." The Board has determined that: (a) all of the participants' appeals involved with the instant EJR request for the three CIRP groups are governed by CMS-1727-R because the participants are challenging a regulation;[34] (b) the participants timely appealed the Part C days issue; and the groups each surpassed the minimum amount in controversy requirement, $50,000. Accordingly, the Board finds jurisdiction over the participants and the CIRP groups, *i.e.*, that their appeals are jurisdictionally proper.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[35] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid

[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] Under ruling 1727-R, 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.
[35] (Emphasis added.)

fractions of the disproportionate patient percentages[,]"[36] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[37] To date, CMS has yet to issue its new final rule.[38]

As the Providers' appeals concern the FY 2010 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR requests concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[39] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[40]

[36] CMS Ruling 1739-R at 1-2.
[37] Id. at 2.
[38] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] (Emphasis added.)
[40] EJR Request at 17.

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[41] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[42]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of a CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [43] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[44]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[45] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive*

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[41] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).
[42] *See Southwest* at 6-7.
[43] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[44] *See* CMS 1739-R at 8.
[45] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers in the three CIRP groups;

2) The Board hereby **denies** Providers' EJR Requests regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers in the three CIRP groups will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers in the three CIRP groups for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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:

1/15/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Justin Lattimore, Novitas Solutions, Inc.

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 Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave., NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Case Nos. 14-3648GC, 14-3649GC
FYE 6/30/2011

Dear Ms. Webster:

The two above-referenced common issue related party ("CIRP") group appeals[1] include 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 2, 2020, the Providers in the above-referenced CIRP group appeals filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Requests, and then grant it in part and deny it in part, is set forth below.

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 . . ."

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

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[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Provider's Request for EJR

The Providers within these CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2011 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
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> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
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[29] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
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> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Analysis and Decision

After review of the Providers' EJR Requests, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP groups and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

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[30] *Id*. at 14.
[31] *Id*. at 17.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2011.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R specifies that: "For such appeals, assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought." The Board has determined that: (a) all of the participants' appeals involved with the instant EJR request for the two CIRP groups are governed by CMS-1727-R because the participants are challenging a regulation;[34] (b) the participants timely appealed the Part C days issue; and the groups each surpassed the minimum amount in controversy requirement, $50,000. Accordingly, the Board finds jurisdiction over the participants and the CIRP groups, *i.e.*, that their appeals are jurisdictionally proper.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[35] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[36] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before

[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] Under ruling 1727-R, 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.
[35] (Emphasis added.)
[36] CMS Ruling 1739-R at 1-2.

October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[37] To date, CMS has yet to issue its new final rule.[38]

As the Providers' appeals in Case Nos. 14-3648GC and 14-3649GC concern the FY 2011 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR requests concerning the Medicare Part C Days issue for Case Nos. 14-3648GC and 14-3649GC.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[39] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[40]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group,*

[37] Id. at 2.
[38] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] (Emphasis added.)
[40] EJR Request at 17.

et al. v. Blue Cross Blue Shield Ass'n, PRRB Dec. No. 2010-D36 (June 14, 2010),[41] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[42]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [43] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[44]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[45] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to

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[41] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[42] *See Southwest* at 6-7.

[43] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[44] *See* CMS 1739-R at 8.

[45] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the remaining Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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:

1/15/2021

X Clayton J. Nix

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

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

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

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway, Suite 620
Plano, TX 75093

RE: ***Expedited Judicial Review Determination***
Southwest Consulting Christus 2012 DSH - SSI Fraction Part C Days CIRP Group
FYE 6/30/2012
Case No. 15-0136GC

Dear Mr. Newell:

The above-referenced common issue related party ("CIRP") group appeal[1] 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 23, 2020, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

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

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] 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

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

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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2012 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after this CIRP group was established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

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[30] *Id*. at 14.
[31] *Id*. at 17.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2012.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R specifies that: "For such appeals, assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought." The Board has determined that: (a) all of the participants' appeals involved with the instant EJR request are governed by CMS-1727-R because the participants are challenging a regulation;[34] (b) the participants timely appealed the Part C days issue; and the group surpassed the minimum amount in controversy requirement, $50,000. Accordingly, the Board finds jurisdiction over the participants and the CIRP group, *i.e.*, that their appeals are jurisdictionally proper.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[35] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[36] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before

[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] Under ruling 1727-R, 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.
[35] (Emphasis added.)
[36] CMS Ruling 1739-R at 1-2.

October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[37] To date, CMS has yet to issue its new final rule.[38]

As the Providers' appeal concerns the FY 2012 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[39] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[40]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[41] in which the

[37] Id. at 2.
[38] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] (Emphasis added.)
[40] EJR Request at 17.
[41] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group

providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[42]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [43] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[44]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[45] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

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appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[42] *See Southwest* at 6-7.

[43] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[44] *See* CMS 1739-R at 8.

[45] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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.

For the Board:

Board Members Participating:

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

1/15/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Justin Lattimore, Novitas Solutions, Inc.

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

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Plano, TX 75093

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
Case Nos. 19-1997GC, 19-2041GC
FYE 2011

Dear Mr. Newell:

The two above-referenced common issue related party ("CIRP") group appeals[1] include 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 26, 2020, the Providers in the above-referenced CIRP group appeals filed requests for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Requests, and then grant it in part and deny it in part, is set forth below.

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

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2011 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.

> federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Decision and Analysis

After review of the Providers' EJR Requests, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP groups and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP group were established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

[30] *Id*. at 14.
[31] *Id*. at 17.

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2011.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R involves dissatisfaction with the Medicare Contractor determinations. The Board determines whether the participants' appeals involved with the instant EJR requests are governed by CMS-1727-R.[34]

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[35] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[36] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[37] To date, CMS has yet to issue its new final rule.[38]

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[32] 42 C.F.R. § 405.1835(a).

[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

[34] Under ruling 1727-R, 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.

[35] (Emphasis added.)

[36] CMS Ruling 1739-R at 1-2.

[37] Id. at 2.

[38] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).

As the Providers' appeals concern the FY 2011 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[39] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[40]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[41] in which the

[39] (Emphasis added.)
[40] EJR Request at 17.
[41] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the

providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[42]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [43] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[44]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[45] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[42] *See Southwest* at 6-7.

[43] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[44] *See* CMS 1739-R at 8.

[45] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers for the group appeals will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers in the group appeals for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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:

1/15/2021

X Clayton J. Nix

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

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

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

Michael Newell
Southwest Consulting Associates
2805 North Dallas Parkway
Plano, TX 75093

RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
Case Nos. 19-2154G, 19-2168G
FYE 2012

Dear Mr. Newell:

The above-referenced two *optional* group appeals[1] include 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 26, 2020, the Providers in the above-referenced optional group appeals filed requests for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Requests, and then grant it in part and deny it in part, is set forth below.

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

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within the optional group appeal are challenging their Medicare reimbursement for the fiscal year 2012 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.
[30] *Id*. at 14.

. . . .

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Decision and Analysis

After review of the Providers' EJR Requests, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the optional groups and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these optional groups were established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

[31] *Id.* at 17.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2012.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R specifies that: "For such appeals, assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought." The Board has determined that: (a) all of the participants' appeals involved with the instant EJR request for the three optional groups are governed by CMS-1727-R because the participants are challenging a regulation;[34] (b) the participants timely appealed the Part C days issue; and the groups each surpassed the minimum amount in controversy requirement, $50,000. Accordingly, the Board finds jurisdiction over the participants and the optional groups, *i.e.*, that their appeals are jurisdictionally proper.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[35] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[36] *i.e.*, the Part C Days issue. Specifically,

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[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] Under ruling 1727-R, 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.
[35] (Emphasis added.)
[36] CMS Ruling 1739-R at 1-2.

CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[37] To date, CMS has yet to issue its new final rule.[38]

As the Providers' appeals concern the FY 2012 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[39] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[40]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group,*

[37] Id. at 2.
[38] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[39] (Emphasis added.)
[40] EJR Request at 17.

et al. v. Blue Cross Blue Shield Ass'n, PRRB Dec. No. 2010-D36 (June 14, 2010),[41] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[42]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [43] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[44]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[45] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to

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[41] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[42] *See Southwest* at 6-7.

[43] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[44] *See* CMS 1739-R at 8.

[45] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers for these group appeals will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers in these groups for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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:

1/15/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Cecile Huggins, Palmetto GBA

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21207
410-786-2671

Via Electronic Delivery

Kenneth Marcus, Esq.
Honigman Miller Schwartz and Cohn LLP
660 Woodward Ave., Ste. 2290
Detroit, MI 48226

RE: ***Expedited Judicial Review Determination***
Edward W. Sparrow Hospital (Prov. No. 23-0230)
FYE 12/31/2012
Case No. 17-0307

Dear Mr. Marcus:

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 ("the Part C Days issue"). The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS 1739-R" or "the Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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."[1]

On December 22, 2020, Edward W. Sparrow Hospital ("Provider") filed its Expedited Judicial Review ("EJR") Request ("EJR Request" or "Request") concerning the Part C Days issue contained within the above-referenced appeal.[2] The Board's decision to bifurcate Provider's EJR Request, and then grant it in part and deny it in part, is set forth below.

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[1] *See* 58 Fed. Reg. 47723 (Aug. 6, 2020).

[2] Provider's November 1, 2016 Request for Hearing, appealed five issues: (1) DSH Supplemental Security Income ("SSI") Systemic Errors; (2) DSH Medicare Advantage (*i.e.*, "Part C Days")/Dual Eligible Days included in the Medicare Fraction; (3) DSH Medicare Part C/Dual Eligible Days excluded from the Medicaid Fraction; (4) Medicare Bad Debt: Non-Crossover Bad Debt, Collection Effort; and (5) Medicare Bad Debt Psychiatry: Non-Crossover Bad Debt, Collection Effort. Within its December 23, 2020 correspondence, Provider withdrew all issues except its two Part C Days issues (Issues 2 & 3) being considered by the Board in this EJR Request. The Board notes that the D.C. Circuit's 2014 decision in *Allina Health Servs. v. Sebelius* held that "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 1102, 1108 (D.C. Cir. 2014). In other words, under 42 U.S.C. § 1395ww(d)(5)(F)(vi), either a Part C enrollee continues to be "entitled to benefits under Part A" or not. Accordingly, the two Part C Days cited by the Provider is really one issue since the legal outcome is binary: either the Provider is successful in excluding Part C days from the SSI fraction (which in turn necessarily means they must be included and counted in the Medicaid fraction); ***or*** the Provider is unsuccessful in excluding them (which in turn necessarily precludes them from being counted in the Medicaid fraction).

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[3] 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].[4]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[5]

With the creation of Medicare Part C in 1997,[6] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

[3] of Health and Human Services.
[4] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[5] *Id.*
[6] 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.

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 years 2001-2004.[7]

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 . . . .*[8]

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."[9] 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.[10]

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

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[7] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[8] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[9] 69 Fed. Reg. at 49099.
[10] *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.[11] 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).[12] 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."[13]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[14] 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.[15] In *Allina Health Services v. Price* ("*Allina II*"),[16] 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*.[17] 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.[18] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[19]

CMS 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling CMS-1739-R. The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling

[11] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[12] *Id*. at 47411.
[13] 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).
[14] 746 F. 3d 1102 (D.C. Cir. 2014).
[15] *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.").
[16] 863 F.3d 937 (D.C. Cir. 2017).
[17] *Id.* at 943.
[18] *Id*. at 943-945.
[19] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[20] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[21] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[22]

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

[20] CMS Ruling 1739-R at 2 (Aug. 17, 2020).
[21] *Id*.
[22] *Id*.

> 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.[23]

Provider's Request for EJR

In the instant appeal, the Provider is challenging its Medicare reimbursement for its fiscal year 2012 cost reporting period. Specifically within its EJR Request, the Provider describes the issues for which it is requesting EJR as follows:

> (1) Before the Board is the Part C Days Issue. In deciding this issue, the Board is bound by the Proposed Rule[24] and the Ruling, the legal validity of which the Provider challenges.
>
> (2) Also before the Board is the validity of the Proposed Rule and the Ruling, the legal validity of which the Provider challenges.[25]

The Provider describes "[t]he underlying interpretive issue" in the instant appeal, and the aforementioned *Allina* cases, as a question of whether "enrollees in Medicare Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction of the DSH adjustment."[26]

The Provider goes on to explain that:

> CMS has not acquiesced to the decision in *Allina*. Instead, CMS has issued a proposed regulation that purports to retroactively restore the DSH Part C policy that the Supreme Court struck down. 85 Fed. Reg. 47723-47728 (Aug. 6, 2020) (the "Proposed Rule"). Shortly after, CMS issued CMS Ruling 1739-R dated August 17, 2020, which purports to divest the Board of jurisdiction over the Part C Days Issue[.][27]

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[23] CMS-1739-R at 6-7.
[24] The Provider describes the "Proposed Rule" in the following manner: "While [Provider's] appeal was pending before the Board, CMS issued a proposed regulation that purports to retroactively restore the DSH Part C policy that the Supreme Court struck down in the *Allina* decision. 85 Fed. Reg. 47723-47728 (Aug. 6, 2020) ("the Proposed Rule")." EJR Request at 1.
[25] EJR Request at 3.
[26] *Id*. at 10 (quoting *Allina*, 746 F.3d at 1105).
[27] *Id*. at 14.

In summarizing the mandates within the Ruling, the Provider explains that following a Board determination that an appeal of the Part C Days issue "satisfies the applicable jurisdictional and procedural requirement of section 1878 of the [Medicare] Act, the Medicare regulations, and any other agency rules and guidance[,]" the Board must remand the appeal to the Medicare Contractor to "recalculate the provider's DSH payment adjustment in accordance with the forthcoming rule."[28]

The Provider points out that "the Ruling claims the proposed rule 'eliminates any actual case or controversy regarding the hospital's previously calculated SSI and Medicaid fractions and its DSH payment adjustment and thereby renders moot each properly pending claim in a DSH appeal involving the issue resolved by the Supreme Court in Allina . . . .'"[29] The Provider acknowledges that "the Board's initial reaction to the Provider's challenge to the Proposed Rule may be that the appeal is premature because the Proposed Rule has not yet been published in final form[,]" but argues that "[t]he Board is bound by the Proposed Rule and Ruling"[30] and the Provider has the right to challenge the Proposed Rule because, in the Ruling, "CMS has taken action based on the Proposed Rule."[31]

The Provider states that "the Board should find the Ruling is unlawful"[32] based on the following arguments:

> (a) The provisions of the Ruling depriving the Board of jurisdiction over otherwise jurisdictionally valid appeals, and declaring appeals moot and requiring the Board to remand them to the Medicare contractors are invalid and must be set aside as inconsistent with 5 U.S.C. § 706(2) and 42 U.S.C. §§ 1395oo(a), (f)(1), 1395hh(a)(2), and 1395hh(e).
>
> (b) The provisions of the Ruling purporting to declare that the Board lacks jurisdiction over appeals of the Part C Days Issue and ordering the Board to remand violate the plain language of 42 U.S.C. § 1395oo(a). . . . Nothing in section 1395oo or any other statute authorizes the agency to divest the hospitals of the appeal rights granted to them, or the Board of the jurisdiction conferred to it, by section 1395oo. . . .
>
> (c) The provisions of the Ruling declaring the Hospitals' claims moot, and the Board's potential application of these provisions in a remand decision, are arbitrary, capricious, not based on substantial evidence, and otherwise contrary to law. . . . The agency's

[28] EJR Request at 16 (quoting the Ruling).
[29] *Id*. at 16-17 (quoting the Ruling at 8).
[30] *Id* at 2, 24.
[31] *Id*. at 20.
[32] *Id*. at 20

> suggestion to the contrary is absurd and cannot be used as an excuse to strip the Board of jurisdiction. . . .
>
> (d) The Ruling requiring remand further violates the special notice-and-comment rulemaking provision of the Medicare Act. 42 U.S.C. § 1395hh(a)(2). . . . If the agency's attempt to apply the vacated 2004 policy was required to undergo notice-and-comment rulemaking, then certainly the attempt to deny hospitals the ability to even challenge these invalid payment determinations, as the Ruling purports to do, similarly violates the requirements of section 1395hh(a)(2). . . .
>
> (e) The application of the Ruling to the Provider is also impermissibly retroactive as applied to the cost year here. See 42 U.S.C. § 1395hh(e). . . . Insofar as the Ruling would retroactively set in stone invalid DSH payment determinations in NPRs reflecting the same DSH Part C policy as reflected in the agency publications vacated in *Allina I* and *Allina II*, the Ruling would violate section 1395hh(e)(1) by retroactively changing the standard for treatment of Part C Days in the DSH calculation. . . .
>
> (f) The Ruling also does not and could not override the Board's statutory duty under 42 U.S.C. § 1395oo(f)(1) to make a determination as to its authority to decide a legal question. . . .
>
> (g) While the Ruling explains that there have been frequent requests for EJR on the Part C Days Issue, Ruling at 6, the Ruling nowhere directs the Board not to rule on EJR requests, to reject these requests solely on the basis of jurisdiction, or even not to review jurisdictional documentation for purposes of making a jurisdictional determination. The Ruling expressly states that the Board "will first determine whether each claim at issue is for the Part C day DSH issue and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act [42 U.S.C. § 1395oo], the Medicare regulations, and other agency rules and guidelines." Ruling at 7. While the Provider challenges the legal validity of the Ruling, if the Board believes that it is bound by the Ruling the Board is obliged to perform this analysis when it considers the Provider's request for EJR. Additionally, it would be entirely inconsistent for the Board to arbitrarily decide here that it does not have jurisdiction over the Provider's appeal without so much as reviewing the jurisdictional documentation, but to at the same time assert that it not need to act upon an EJR request at all. . . . [33]

[33] EJR Request at 20-23.

Board's Analysis and Decision

The Provider's EJR Request presents separate and distinct issues for the Board to consider.

The first issue is the Provider's challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which Provider bases its EJR Request and is the source of Provider's dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. The Provider has raised multiple legal arguments in support of this challenge (marked "a" to "g" above). This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after Provider's appeal was filed). Embedded within this issue is also the Provider's challenge to the Proposed Rule issued 11 days earlier on August 6, 2020.

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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 Regarding the Part C Days Issue within Provider's Request for Hearing

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing for Provider on the specific matter at issue. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[34, 35]

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

[34] 42 C.F.R. § 405.1835(a).
[35] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

Association v. Bowen.[36] 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.[37]

On August 21, 2008, new regulations governing the Board were effective.[38] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner).*[39] 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.[40]

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[41] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[42]

Here, Provider filed its November 1, 2016 Request for Hearing from its September 2, 2016 original NPR that final settled its cost reporting period ending on December 31, 2012. At the time that it filed its Request for Hearing, Provider estimated that the amount in controversy for the Part C Days issues was $200,000. In addition, based on the filing date and cost reporting period under appeal, Provider's appeal falls under the mandates of CMS-1727-R.

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[36] 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.).
[37] *Bethesda* at 1258-59.
[38] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[39] 201 F. Supp. 3d 131 (D.D.C. 2016)
[40] *Banner* at 142.
[41] CMS Ruling CMS-1727-R at 1-2.
[42] *Id*. at unnumbered page 7.

The Board finds that Provider timely filed its appeal and that its documentation shows that the estimated amount in controversy exceeds the $10,000 required for an individual appeal. The Board has also determined that Provider's Part C Days issue(s)[43] were "subject to a regulation or other payment policy that bound the [Medicare Contractor] and left it with no authority or discretion to make payment in the manner sought by [P]rovider" thus rendering futile its cost reimbursement claim and ultimately satisfying the dissatisfaction prong of 42 C.F.R. § 405.1835(a).[44] Accordingly, the Board finds that Provider has shown that it has a right to a hearing before the Board under 42 C.F.R. § 405.1835(a), *i.e.*, that the Provider's appeal is jurisdictionally proper. The Board notes that the estimated amount in controversy is subject to the Medicare Contractor's recalculation of the actual final amount in the instant case.

EJR Determination for the Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[45] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[46] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[47] To date, CMS has yet to issue its new final rule.[48]

As the Provider's appeal concerns its fiscal year 2012 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Pursuant to 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[49] Accordingly, the Board will issue, under separate cover, a remand for Provider's Part C Days issue as Provider has a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determined ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

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[43] Request for Hearing, at Tab 3, Issues 2 & 3.
[44] CMS 1727-R at unnumbered page 6.
[45] (Emphasis added.)
[46] CMS Ruling 1739-R at 1-2.
[47] *Id*. at 2.
[48] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[49] (Emphasis added.)

Validity of CMS Ruling 1739-R

Within the EJR Request, the Provider also challenges the validity of CMS Ruling 1739-R and the Proposed Rule referenced within the Ruling, as quoted extensively, *supra*.

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[50] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[51]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of a CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [52] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim *as of August 17, 2020*.[53]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a

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[50] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[51] *See Southwest* at 6-7.

[52] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.

[53] *See* CMS 1739-R at 8.

challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[54]

Here, the Provider essentially challenges the Board's *application* of the CMS Ruling 1739-R, including the Proposed Rule referenced within the Ruling.

With respect to the Ruling, the Provider challenges the validity of the mandate within the Ruling that, *as of August 17, 2020,* purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***and*** that it lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

The Board recognizes that the Provider has also raised questions challenging the validity of the August 6, 2020 Proposed Rule. The question posed by the Provider regarding the Proposed Rule appears rooted in the Ruling itself: "if CMS believes as it apparently does that the Proposed Rule authorizes CMS to take action, than the Provider has the right to challenge the Proposed Rule and the threatened remand action under the Ruling."[55] However, contrary to the Provider's position, the authority for the Ruling does not flow from the Proposed Rule. Rather, the Ruling sets forth a process to resolve and render moot the Part C issue and this process includes a rulemaking of which the Proposed Rule is just one step and which ultimately will yield a final binding determination in the form of a final rule.

To the extent the Provider's EJR request challenges, *on a separate and independent basis,* the validity of the August 6, 2020 Proposed Rule, then the Board finds it to be premature[56] and not a question that the Board can certify for EJR. In this regard, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board notes that it can only grant EJR with respect to "any action of the [Medicare Contractor] which involves *a question of law or regulations* relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the

[54] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).
[55] EJR Request at 20.
[56] The Board notes that, while the Ruling takes away the Board's substantive jurisdiction over the Part C days issue as of August 17, 2020, a remanded provider would necessarily have renewed appeal rights for the Part C days issue (as that issue is modified by the final rulemaking yet to be issued per the Ruling) since the provider would receive a revised NPR and would have appeal rights pursuant to 42 C.F.R. § 405.1889(b) which is referenced in § 405.1835(a)(1). This is consistent with how remands of the SSI data matching process issue were handled pursuant to Ruling 1498-R and the appeal rights providers have had with the resulting revised NPRs incorporating SSI fractions calculated pursuant to that 1498-R remand. *See, e.g., Empire Health Found. v. Burwell*, 209 F. Supp. 3d 261 (D.D.C. 2016) (granting Secretary's Rule 12(b)(1) motion to dismiss due to further appeal rights under 1498-R. *Caveat,* in determining whether to grant a 12(b) motion to dismiss, the Court "treat[s the Complaint's] factual allegations as true and grant[s] the plaintiff the benefit of all reasonable inferences that can be derived from the alleged facts" *id.* at 266).

question."[57] The Secretary implemented this statutory provision at 42 C.F.R. § 405.1842 which specifies in subsection (a)(1):

> This section implements provisions in section 1878(f)(1) of the Act that give a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (***as described in § 405.1867 of this subpart***, which explains the scope of the Board's legal authority).[58]

Significantly, this regulations cross-references 42 C.F.R. § 405.1867 which addresses the "Scope of Board's legal authority" stating:

> In exercising its authority to conduct proceedings under this subpart, the Board *must comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder*, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[59]

Thus, to the extent the EJR request is ***alone*** challenging the validity of the Proposed Rule, then it would not be a valid legal question for the Board to EJR since the Proposed Rule is not yet final and binding and cannot be construed as a "regulation" under § 405.1867.[60] To this end, the Proposed Rule allowed for a 60-day period for comments for "consideration" by the Secretary and, based on these comments, the Secretary may decide to revise the proposed rulemaking.[61]

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[57] (Emphasis added.)
[58] (Emphasis added.)
[59] (Emphasis added.)
[60] Similarly, 42 C.F.R. § 405.1840(c)(1) mandates that "[i]n issuing an EJR decision under § 405.1842 of this subpart[,] the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue in each contractor or Secretary *determination* under appeal." (Emphasis added.) Here, while the Provider did ***not*** file its appeal on the Proposed Rule, the Board notes that the Proposed Rule itself cannot itself be considered an appealable "final determination" under the plain language of 42 U.S.C. § 1395oo(a)(1)(A) and (f)(1), and the Secretary's regulations that implement those statutory mandates, 42 C.F.R. §§ 405.1835(a), 405.1840 and 405.1842. Specifically, under 42 U.S.C. § 1395oo(a)(1)(A)(ii), in pertinent part, a provider of services has a right to a Board hearing if such provider "is dissatisfied with a *final determination* of the Secretary as to the amount of payment under subsection (b) or (d) of section 1395ww of this title." (Emphasis added.) In turn, under 42 U.S.C. § 1395oo(f)(1), "*[i]f a provider of services may obtain a hearing under subsection (a)* and has filed a request for such hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy[.]" (Emphasis added.)
[61] 85 Fed. Reg. at 47723.

That said, the Board's finding that any direct challenge of the Proposed Rule is premature does not mean that the Proposed Rule is irrelevant to the portion of the EJR request that Board is granting. In making its ruling here, the Board recognizes that the Proposed Rule may relevant to and an integral part of the Provider's arguments challenging the validity *of the Ruling itself* and for which the Board is granting EJR.

In summary, to the extent the EJR request is ***alone*** challenging the validity of the Proposed Rule, the Board hereby dismisses that *direct* challenge to the Proposed Rule because such a challenge is premature and not eligible as an independent and separate basis for EJR (*i.e.*, separate and apart from the challenge to the Ruling itself). The Board hereby grants the EJR request regarding the validity of the mandate within the Ruling that, *as of August 17, 2020*, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***and*** that it lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear Provider's appeal of its Medicare Part C days issue and its challenge to the validity of CMS-1739-R, as narrowed below;

2) To the extent the Provider's EJR request challenges, *on a separate and independent basis*, the validity of the August 6, 2020 Proposed Rule, then the Board hereby **dismisses** that *direct* challenge from the EJR request because such a challenge is premature and not eligible as an independent and separate basis for EJR;

3) The Board hereby **denies** Provider's EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the remaining Providers will receive a remand letter of this issue under separate cover; and

4) The Board hereby **grants** Provider's EJR Request for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.[62]

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As no issues remain pending in the appeal, Case No., 17-0307 is closed and removed from the Board's docket.

[62] The Provider questions the validity of the Ruling based on arguments "a" to "g" discussed *supra*.

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:

1/19/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Byron Lamprecht, WPS Government Health Administrator

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 Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave., NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Allina Health 2012 DSH Medicare Advantage Days CIRP Group
Case No 16-0340GC

Dear Ms. Webster:

The above-referenced common issue related party ("CIRP") group appeal[1] 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. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the 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 October 1, 2020, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue. The Board's decision to bifurcate the Providers' EJR Request, and then grant it in part and deny it in part, is set forth below.

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

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).

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[2] 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].[3]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[4]

With the creation of Medicare Part C in 1997,[5] 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 years 2001-2004.[6]

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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[2] of Health and Human Services.
[3] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[4] *Id.*
[5] 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.
[6] 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 . . . .*[7]

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."[8] 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.[9]

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.[10] 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).[11] As a result of these rulemakings, Part C days were

[7] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[8] 69 Fed. Reg. at 49099.
[9] *Id.* (emphasis added).
[10] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[11] *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."[12]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[13] 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.[14] In *Allina Health Services v. Price* ("*Allina II*"),[15] 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*.[16] 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.[17] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[18]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[19] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[20] The

[12] 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).
[13] 746 F. 3d 1102 (D.C. Cir. 2014).
[14] *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.").
[15] 863 F.3d 937 (D.C. Cir. 2017).
[16] *Id.* at 943.
[17] Id. at 943-945.
[18] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[19] CMS Ruling 1739-R (Aug. 17, 2020).
[20] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[21]

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.[22]

[21] *Id*.
[22] CMS Ruling 1739-R at 6-7.

Providers' Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2012 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[23] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[24] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[25] As such, the Providers conclude that the Board is "required" to grant EJR.[26]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[27] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[28]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[29]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[23] EJR Request at 1.
[24] *Id*. at 1.
[25] *Id*.
[26] *Id*. at 1-2.
[27] *Id*. at 11-12.
[28] *Id*. at 21.
[29] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[30]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[31]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the 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, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that, as of August 17, 2020, divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after this CIRP group was established).

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) 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.

[30] *Id*. at 14.
[31] *Id*. at 17.

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[32, 33]

With respect to the "dissatisfaction" prong of the Board's jurisdiction regulation, for cost report periods ending prior to December 31, 2008, a provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen*.[34] 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.[35]

On August 21, 2008, new regulations governing the Board were effective.[36] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[37] 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.[38]

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[32] 42 C.F.R. § 405.1835(a).
[33] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[34] 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.).
[35] *Bethesda* at 1258-59.
[36] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[37] 201 F. Supp. 3d 131 (D.D.C. 2016).
[38] *Banner* at 142.

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R ("CMS 1727-R") which involves dissatisfaction with the Medicare Contractor determinations for cost report periods that ended on or after December 31, 2008, and began before January 1, 2016, that were pending or filed on or after April 23, 2018.[39] Under this Ruling, if 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) is no longer applicable. However, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.[40]

The Providers included in the instant EJR request filed appeals of either original Notices of Program Reimbursement ("NPRs") or revised NPRs ("RNPRs") in which the Medicare contractor settled cost reporting periods ending in 2012. For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, CMS Ruling CMS-1727-R applies.[41]

Based on the filing date and cost reporting period under appeal, the Providers in this CIRP group who filed appeals from original NPRs fall under the mandates of CMS-1727-R. The Board further finds that their appeals are permitted under the dictates of CMS-1727-R because they had to self-disallow based on the regulation at issue and are challenging the validity of that regulation.

The remaining Providers filed their respective appeals from RNPRs.[42] The Board notes that, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. Here, CMS specifically revised the Providers' SSI percentages and then the Medicare Contractor used the new SSI fraction to recalculate Providers' DSH adjustments.[43]

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[39] CMS Ruling CMS-1727-R at 1-2.
[40] *Id*. at unnumbered page 7.
[41] Under Ruling 1727-R, 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.
[42] See attachment A.
[43] In other words, a by-product of CMS going through the new data matching process delineated in the FY 2011 IPPS final rule published on August 16, 2010 (75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010)) to issue a new SSI percentage is that CMS generates new or revised "days" data that results in a revised or new SSI percentage. Unless there is evidence to the contrary (which there is not), the Board must assume that the updated "days" data resulting from the new data match process included revisions or changes to Part C days included in that data. The Providers are challenging the regulation promulgated in the August 11, 2004 final rule that requires these Part C days to be counted in the SSI fraction.

Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[44] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP appeal 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.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[45] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[46] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates before October 1, 2013[,] that arise from [NPRs] 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 . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[47] To date, CMS has yet to issue its new final rule.[48]

As the Providers' appeal concerns the FY 2012 cost reporting period, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[49] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

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[44] *See* 42 C.F.R. § 405.1837.
[45] (Emphasis added.)
[46] CMS Ruling 1739-R at 1-2.
[47] Id. at 2.
[48] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[49] (Emphasis added.)

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[50]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[51] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[52]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that

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[50] EJR Request at 17.

[51] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[52] *See Southwest* at 6-7.

CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [53] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[54]

As noted prior, the Board must grant EJR if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute, or to the substantive or procedural validity of a regulation or CMS Ruling.[55] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that, as of August 17, 2020, purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeal (*i.e.*, the appeals are jurisdictionally proper);

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive a remand letter of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that, as of August 17, 2020, divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. 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.

[53] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[54] *See* CMS 1739-R at 8.
[55] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

Board Members Participating:

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

For the Board:

1/21/2021

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.

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

The Rybar Group, Inc.
Ronald Rybar
3150 Owen Road
Fenton, MI 48430

WPS Government Health Administrators
Byron Lamprecht
2525 N 117th Ave., Ste. 200
Omaha, NE 68164

RE: ***Jurisdictional Decision***
Scenic Mountain Medical Center (Prov. No. 45-0653)
FYE 12/31/2011
Case No. 14-3463

Dear Mr. Rybar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case and the Board's jurisdictional determination are set forth below.

Pertinent Facts:

The Provider is a Sole Community Hospital ("SCH"). The Provider filed its appeal request on May 13, 2014, from its Notice of Program Reimbursement dated November 14, 2013. The appeal request stated the issue as "[t]his request is for a volume decrease payment settlement for the fiscal year ending December 31, 2011."

On June 1, 2020, the Medicare Contractor filed a Jurisdictional Challenge in this case. The Medicare Contractor contends that because the Provider failed to make a valid VDA request, the Board lacks jurisdiction of the lone issue in this appeal.

In support of its position, the Medicare Contractor cites to the controlling regulation, found at 42 C.F.R. § 412.92(e) which specifies the process for a SCH to request a VDA, the Medicare Contractor's review and determination of that request, and the SCH's right to appeal that Medicare Contractor's determination. Specifically, this regulation at paragraph 2 requires the SCH to submit its VDA request to the Medicare Contractor:

> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, *a sole community hospital must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement –*
>
> (i) *Submit to the MAC* documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

> (ii) Show that the decrease is due to circumstances beyond the hospital's control.[1]

The Medicare Contractor contends that the Provider's appeal request ***neither*** includes any assertion or documentary support that its request for a VDA was ever made to the Medicare Contractor ***nor*** references any previous request made to the Medicare Contractor for the cost report at issue. The Medicare Contractor recognized that the Provider may argue that it relies on the 05/13/2014 appeal as its request to the Medicare Contractor for a VDA. However, the Medicare Contactor argues that any such reliance would be misplaced because the regulation is clear in specifying the requirement that the SCH's request is to be submitted to the Medicare Contractor, and ***not*** to the Board via an appeal request. The purpose of this requirement is obvious in that the Provider must give the Medicare Contractor the opportunity to review and make a determination before appealing the VDA to the Board. Accordingly, the Medicare Contractor concludes that the Provider has failed to exhaust all available remedies before filing its appeal before the Board.

The Provider has not filed a response to the Medicare Contractor's Jurisdictional Challenge.

Board Decision:

The Board finds that it does ***not*** have jurisdiction over the Provider's appeal. The regulations at 42 C.F.R. § 412.92(e) clearly state the requirements for a Provider to request a VDA payment:

> (e) *Additional payments to sole community hospitals experiencing a significant volume decrease*.
>
> (1) For cost reporting periods beginning on or after October 1, 1983, the MAC provides for a payment adjustment for a sole community hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (e)(2) of this section a more than five percent decrease in its total discharges of inpatients as compared to its immediately preceding cost reporting period. If either the cost reporting period in question or the immediately preceding cost reporting period is other than a 12-month cost reporting period, the MAC must convert the discharges to a monthly figure and multiply this figure by 12 to estimate the total number of discharges for a 12-month cost reporting period.
>
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a sole community hospital must submit its request no later than 180 days **after the date on the MAC's Notice of Amount of Program Reimbursement** -

[1] (Emphasis added.)

(i) Submit to the MAC documentation demonstrating the size of the decrease in discharges, and the resulting effect on per discharge costs; and

(ii) Show that the decrease is due to circumstances beyond the hospital's control.

(3) Effective for cost reporting periods beginning before October 1, 2017, the MAC determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and the hospital's total DRG revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105). Effective for cost reporting periods beginning on or after October 1, 2017, the MAC determines a lump sum adjustment amount equal to the difference between the hospital's fixed Medicare inpatient operating costs and the hospital's total MS-DRG revenue based on MS-DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part and additional payments made for inpatient operating costs for hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105) multiplied by the ratio of the hospital's fixed inpatient operating costs to its total inpatient operating costs.

(i) In determining the adjustment amount, the MAC considers -

(A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;

(B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and

(C) The length of time the hospital has experienced a decrease in utilization.

(ii) The MAC makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.

> (iii) **The MAC determination is subject to review under subpart R of part 405 of this chapter**.[2]

Accordingly, it is clear that 42 C.F.R. § 412.92(e)(3)(iii) specifies that a provider must file a VDA request no later than 180 days ***after*** the issuance date of its NPR and that any appeal rights flow from the MAC's determination on that VDA request. Here, the Provider filed its appeal to the Board based on the original NPR dated November 14, 2013 (as opposed to an appeal based on a VDA determination) and failed to file the VDA request, as required by 42 C.F.R. § 412.92(e). As a result, the Provider's appeal of the VDA issue is premature because it is not appealing from a VDA determination (and, in fact, there is no evidence showing that there was in fact a VDA determination by the MAC). Therefore, based on the above findings, the Board lacks jurisdiction over this issue under 42 C.F.R. § 412.92(e) and dismisses it from the appeal.[3]

As the VDA issue is the only issue in the appeal, the Board closes Case No. 14-3463 and removes it 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:

1/21/2021

X Clayton J. Nix

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

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

[2] (Bold emphasis added.)
[3] *See* 53 Fed. Reg. 38476, 358511, 38529 (Sept. 30, 1988) (incorporating the current requirements into 42 C.F.R. § 412.92(e) and noting that these requirements were first adopted in the preamble September 1, 1983 final rule); 48 Fed. Reg. , 39782 (Sept. 1, 1983) (stating the following regarding requests for a VDA: "The hospital's request must be made to its intermediary within 180 days of the date on the intermediary's notice of program reimbursement. The intermediary will make a recommendation on the hospital's request to HCFA, which will make the decision. We will respond to the request through the intermediary, within 180 days of the date we receive the request from the intermediary. HCFA's decision will be reviewable under the provisions of Subpart R of 42 CFR Part 405.").

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 Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Avenue NW
Washington, DC 20006

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

RE: ***Jurisdictional Determination***
Rochester Regional Health CY 2013 DSH Part C Days - On/After 10/1/2013 CIRP Group
Case No. 20-1528GC

Dear Ms. Webster and Ms. VanArsdale:

The Provider Reimbursement Review Board ("Board") has reviewed the above-referenced group appeal and finds an impediment to jurisdiction. The pertinent facts of the case and the jurisdictional decision of the Board, are set forth below.

Pertinent Facts:

Ropes & Gray, LLP ("Ropes & Gray") filed the subject group appeal on April 3, 2020. The issue statement indicates the group is appealing:

> . . . CMS's treatment of Medicare Advantage days in the determination of the Providers' DSH percentage for both operating and capital DSH. The Providers contend that all Medicare Advantage days should be excluded from the Medicare Part A/SSI fraction and Medicaid-eligible portion of these days should be counted in the numerator of the Medicaid fraction.

The group was formed with:

Participant 1: Newark-Wayne Community Hospital (33-0030) 12/31/2013

- Reopening Request dated March 29, 2019
  - Reopening Request included the following language:
    The Provider ". . .hereby exercises it privilege granted under 412.106(b)(3) and requests that its DSH SSI fraction be recalculated based upon its cost reporting year ended December 31, 2013."
- Reopening Notice dated April 8, 2019
  - The cost report is being reopened for the following issue:
    "To review the DSH payment calculation for the realigned SSI based on the cost reporting period."
- Revised NPR dated October 10, 2019

- Audit Adjustment 1: was made to adjust the SSI % and Medicare DSH % to audited amount in accordance with . . . 42 CFR 412.106(d).

On April 20, 2020, the MAC identified an impediment to the Board's jurisdiction over the initial participant forming the group (Newark-Wayne Community Hospital) which was appealing from a Revised NPR.

On April 23, 2020, Ropes & Gray added a second participant to the group:

Participant 2: Rochester General Hospital (33-0125) FYE 12/31/2013

- Reopening Request dated April 29, 2019
  - Reopening Request included the following language: The Provider ". . .hereby exercises it privilege granted under 412.106(b)(3) and requests that its DSH SSI fraction be recalculated based upon its cost reporting year ended December 31, 2013."
- Reopening Notice dated May 7, 2019
  - The cost report is being reopened for the following issue: "To review the DSH payment calculation for the realigned SSI based on the cost reporting period."
- Revised NPR dated October 28, 2019
- Audit Adjustment 1: was made to adjust the SSI % and Medicare DSH % to audited amount in accordance with . . . 42 CFR 412.106(d).

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 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)[1] explains the effect of a cost report revision:

[1] *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).

> (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.

The Board finds that it does not have jurisdiction over the DSH Part C Days - On/After 10/1/2013 issue for the two Providers in this group (Newark-Wayne Community Hospital and Rochester General Hospital) that filed from revised NPRs because the revised NPRs were issued as a result of the Providers' SSI Realignment requests, and did not adjust the DSH Part C Days - On/After 10/1/2013 issue, which is the issue under appeal in this group.

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[.]"[2] The reopening for both of these participants were issued as a result of the Providers' requests to realign their SSI percentages from the federal fiscal year end to the individual cost reporting fiscal year ends. Further, the audit adjustments associated with the revised NPRs under appeal for both participants clearly only revised the SSI percentages in order to realign them from a federal fiscal year to the providers' respective fiscal years.[3] In other words, the determinations were only being reopened to include the realigned SSI percentages. Since the only matters specifically

[2] 42 C.F.R. § 405.1889(b)(1).

[3] 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)).

revised in the revised NPRs were adjustments related to the realigned SSI percentages, the Board does not have jurisdiction over these two participants in the group.

In conclusion, Newark-Wayne Community Hospital and Rochester General Hospital) are dismissed from the appeal as they do not have the right to appeal the revised NPRs at issue under 42 C.F.R. §§ 405.1889 and 405.1835(a)(1) which cross-references § 405.1889.[4, 5] Accordingly, the Board hereby closes Case No. 20-1528GC. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

1/29/2021

X Clayton J. Nix

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

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

[4] Cases upholding the Board's interpretation of 42 C.F.R. § 405.1889. *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).

[5] The Board further notes that Rochester Regional Health previously had 2 prior cases for the same Part C days issue (one for each fraction) under Case Nos. 17-0218GC and 17-0217GC (appeals presumably based on original NPRs). However, on January 12, 2018, the Board dismissed both of them due to the Providers' failure to file its position paper by the Board filing deadline. On March 13, 2018, the Providers filed a requested reconsideration, schedule of providers certifying that the group was complete and a request for EJR. On March 20, 2018, the Board denied the reconsideration request and denied the EJR request. *See* Board Rule 4.6.3 (stating "Once an issue is dismissed or withdrawn, the issue may not be appealed in any other case.).