DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster
Akin Gump Strauss Hauer & Feld, LLP
2001 K Street, N.W.
Washington, DC 20026

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

RE: ***Request to Form Appeal or, Alternatively, Reinstate Case No. 06-1065GC***
St. John's Regional Medical Center (Provider No. 26-0001)
FYE 6/30/2004
Case No. 18-1344

Dear Ms. Webster and Mr. Lamprecht:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the jurisdictional review challenging the Board's jurisdiction over the Provider, St. John's Regional Medical Center. As set forth more fully below, consistent with CMS Ruling 1498-R ("Ruling 1498-R"), the Board is denying jurisdiction over this Provider and denying the Providers' alternative request for reinstatement of Case No. 06-1065GC. Notwithstanding, the Board has determined that the Medicare Contractor failed to follow the Board's original 1498-R "Standard Remand" Order dated December 9, 2013 as it relates to the following participant in Case No. 06-1065GC:

> St. John's Reg'l Med. Ctr., Provider No. 26-0001, FYE 6/30/2004 ("St. John's" or "Provider").

Accordingly, ***the Board hereby orders the Medicare Contractor*** *to recalculate the DSH payment adjustment for St. John's as mandated by the December 9, 2013 Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h). *If the Medicare Contractor refuses or fails to implement the Board's December 9, 2013 Order as it relates to St. John's* ***within 30 days of the date of this letter (i.e., by Thursday, December 5, 2019)***, the Providers may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c). Further, as there is no final determination, Case No. 18-1134 shall be closed.

Background

On December 9, 2013, the Board issued a 1498-R "Standard Remand" Order to remand Case No. 06-1065GC to the Medicare Contractor "for recalculation of the Providers' DSH

adjustments." At issue in this matter is a request from the Provider to establish a new appeal, or in the alternative, a reinstatement of the original appeal, Case No. 06-1065GC. This request stems from the MAC's remand denial of the Provider from an original 1498-R Standard Remand Order, signed by the Board on December 9, 2013.[1]

A. Overview of the Original Group Appeal under Case No. 06-1065GC and the 1498-R Remand

The hearing request for Case No. 18-1344 was submitted to the Board on June 5, 2018.[2] On June 15, 2018, the MAC submitted a jurisdictional review challenging the Board's jurisdiction over St. John's. St. John's was originally part of a FYE 2004 Group Appeal, Case No. 06-1065GC, *CHI 04 LDR Days Group*.[3] St. John's requested a revised cost report settlement to recognize additional Medicaid eligible days to be included in the numerator of the Medicaid fraction and the calculation of their disproportionate patient percentage ("DPP"). In addition, the Provider requested the MAC to remove Labor and Delivery ("L&D") days from total days, the denominator of the Medicaid fraction. On January 26, 2009, the MAC issued the Notice of Correction of Program Reimbursement ("NCPR"), which included Adjustment 4, removing the 220 L&D days from the total days of the Medicaid fraction and adding 985 Medicaid eligible days to the numerator of the Medicaid fraction.[4] On July 15, 2009, the Provider requested to be added to CHI 2004 DSH Labor & Delivery Room Days Group (Case No. 06-1065G), based on Adjustment No. 4 of the NCPR.[5]

The Provider's original appeal was appealing an issue that falls within the provisions of CMS Ruling 1498-R. Specifically, they contend that CMS and the MACs improperly failed to include labor and delivery room days in the number of the Medicaid patient days used for purposes of calculating DSH, and thereby failed to pay the hospitals' proper DSH entitlements.[6]

Regarding the originally assessed jurisdictional requirements, and whether the Providers preserved their right to claim dissatisfaction with the specific item at issue (or self-disallowed cost for reports after 12/31/08), the following applied:

- All of these Providers are appealing from original NPRs, they have filed jurisdictionally valid appeals pursuant to the rationale in *Bethesda*.

- Further, the Board has jurisdiction over Providers that appealed from revised NPRs because the *Intermediary considered Medicaid eligible labor and delivery room days in each of the reopenings; in each instance*

[1] Provider's Request for Hearing (June 5, 2018).
[2] *Id*.
[3] PRRB Case No. 06-1065GC
[4] MAC's Preliminary Position Paper, at 3 (Apr. 26, 2019).
[5] *Id*.
[6] *Id*., at Remand Letter (dated Dec. 9, 2013).

> *the Intermediary removed the labor room days from the Medicaid eligible days total rather than including the days.*[7]

The amount in controversy was $55,018 for St. John's, and the Provider filed a request with the Board for a hearing within 180 days of the date of its NPR. The emphasized statements above are the primary issue regarding jurisdiction as raised by the MAC in its denial letters.

On April 28, 2010, CMS issued Ruling 1498-R to address, in part, "DSH appeals challenging the exclusion from the DPP of labor/delivery room (LDR) inpatient days"[8] and required the Board "to remand each qualifying appeal to the appropriate Medicare contractor."[9]

On November 17, 2010, the Providers requested Expedited Judicial Review ("EJR") relating to certain aspects of Ruling 1498-R. Concurrent with that request, the Providers submitted certain "additional documentation to further establish the Board's jurisdiction over the appeals from revised NPRs," including documentation and information specifically addressing the Board's jurisdiction over St. John's. On November 24, 2010, the Medicare Contractor submitted its brief in opposition to the Providers' EJR request. However, the Medicare Contractor did not respond to or comment on the additional jurisdictional documentation submitted concurrent with the Providers' EJR request. On December 16, 2010, the Board denied the Providers' EJR request.

In response to CMS Ruling 1498-R, and given the immense backlog of cases needing processing under the ruling, that case was analyzed for jurisdiction in December of 2013. The Board ruled that jurisdiction was proper for all remaining providers, including St. John's (Provider No. 26-0001), and using the Standard Remand procedure provided for in 1498-R, remanded that case to the MAC for recalculation of L&D Days.[10]

The Board applied the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R to Case No. 06-1065GC and, on December 9, 2013, issued the 1498-R "Standard Remand" Order for Case No. 06-1065GC.[11] In this Order, the Board found that "this appeal satisfies the applicable jurisdictional and procedural requirements of 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-1840." Accordingly, the Order remanded all remaining participants in Case No. 06-1065GC "to the [Medicare Contractor" for recalculation of the Providers' DSH adjustment."

B. The Medicare Contractor's Denial of Remand Following the 1498-R Standard Remand Order

On December 5, 2017, the MAC sent a letter stating their determination that St. John's did not meet the requirements for remand per 1498-R.[12] Specifically, the MAC stated:

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[7] (Emphasis added).
[8] CMS Ruling 1498-R at 12.
[9] *Id.* at 1.
[10] PRRB Letter of Standard Remand under Ruling 1498-R (Dec. 9, 2013).
[11] PRRB Letter of Standard Remand under Ruling 1498-R (Dec. 9, 2013).
[12] *See* Provider's Request for Hearing, at Ex. 1. (Letter dated Dec. 5, 2017)

> We have received the documentation to support additional disproportionate share hospital (DSH) payments for labor and delivery room days (L&D) pursuant to the remand request under the terms of CMS Ruling 1498-R. We have reviewed this documentation and we have determined it does not meet the requirements for the following reason(s):
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> "Remand requirements per 1498-R were not met. *Appeal based on a reopening that did not remove L&D days*."[13]

The Medicare Contractor also included the following statement suggesting that St. John's had the right to request reinstatement of the original group appeal: "If you disagree with our determination, you have the right to resume your original appeal of this issue in accordance with 42 CFR 405.1801 – 405.1889." Significantly, the Medicare Contractor did not include any language in the letter to "inform the provider of its right to contractor or Board hearing . . . and that the provider must request the hearing within 180 days after the date of receipt of the notice" as required by 42 C.F.R. § 405.1803 for each "notice of amount of program reimbursement."

In response to these letters, the Provider petitioned to the Board to form a new appeal, challenging the MAC's final determination in those matters.[14] In their request, the group representative characterizes the issue as the MAC's illegal refusal to perform its nondiscretionary duty to effect payment revisions under a final Board order.[15] The Provider notes that the Board, in its remand order, had found that the appeal and the providers satisfied the applicable jurisdictional and procedural requirements. The Provider states that it believes that the MAC does not have discretion to decide not to comply with the Board's final order.[16] Further, they state that the only situation when the MAC is permitted to make jurisdictional findings after a remand by the Board is under the "alternative remand" procedure established under 1498-R, which was not utilized in this remand.[17] Finally, the Provider notes that the Board has jurisdiction from these remand denials because they are final determinations, they are dissatisfied, and they are filed timely within 180 days.[18]

Board Determination

A. Denial of the Provider's Request to Form Group Appeal or, Alternatively, Reinstate Case No. 06-1065GC

The group representative is asking the Board to either proceed with the new appeal based on the Medicare Contractor's December 5, 2017 determination, or to reinstate the original appeal so that the challenge against the denial may move forward. Under 42 C.F.R. § 401.108(b)-(c)

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[13] *Id.* (emphasis added).
[14] Provider's Request for Hearing (June 5, 2018).
[15] *Id*. at Ex. 3, Issue Statement.
[16] *Id*.
[17] *Id*.
[18] *Id.* (Further, MAC's notice states Provider's appeal rights with regards to that final determination).

(2011), CMS Rulings are published under the authority of the CMS Administrator and serve as precedent final opinions and orders or statements of policy or interpretation. Accordingly, CMS Rulings are binding on all Department of Health and Human Services, Social Security Administration and CMS components that adjudicate matters under the jurisdiction of CMS, including the Board pursuant to 42 C.F.R. § 405.1867.

Here, within CMS-1498-R, the CMS Administrator has spoken directly on the issue of Board jurisdiction over the L&D Days DSH issue and subjected that issue to mandatory remand.[19] In the present case, once the Board initially determined that the groups' L&D Days DSH issue for FY 2004 was within CMS-1498-R's mandates, the Board no longer had jurisdiction over the issue and was required to remand the issue to the Medicare Contractor. Nothing within CMS-1498-R suggests that the Board may reassume jurisdiction over this issue once it has been remanded.

In fact, CMS-1498-R states that, upon remand, "CMS' action eliminates *any* actual case or controversy regarding the hospital's previously calculated L&D Days, SSI fraction, and DSH payment adjustment *and thereby renders moot* each properly pending claim in a DSH appeal involving the hospital's previously calculated SSI fraction and the process by which CMS matches Medicare and SSI eligibility data, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[20] The Ruling further provides "that the [Board] and the other administrative tribunals lack jurisdiction over provider appeals of any of [these] three issues."[21] Accordingly, the Board was divested of its authority to act on this case as soon as the Board determined that the Providers' claims satisfied the applicable jurisdictional and procedural requirements for appeal and remanded the L&D Days issue to the Medicare Contractor. As a consequence of this divestiture, the Board must conclude that the case cannot proceed in its current form.[22]

Similarly, the Board finds that this matter is not yet ripe for formation of an individual appeal because the December 5, 2017 letter from the Medicare Contractor addressing St. John's was improper and void because the Medicare Contractor lacked authority under Ruling 1498-R to make the findings that St. John's did not meet the jurisdictional requirements for a Board hearing

[19] Ruling 1498-R at 6.
[20] *Id.* at 6.
[21] *Id.* at 1.
[22] For any appeal filed with the Board, the Board must make jurisdictional findings pursuant to 42 C.F.R. § 405.1840. The alternative method bypasses Board review of jurisdiction under § 405.1840 by having the Medicare Contractor make jurisdictional findings in lieu of the Board. Accordingly, the alternative method is only applied *if and only if* the provider requests it. Similarly, apparently in recognition of § 405.1840, Ruling 1498-R specifies that, *under this alternative method*, if the Medicare contractor finds that the "claim does not meet all applicable jurisdictional and procedural requirements," a provider "may resume without prejudice its original appeal of the same claim before the same administrative appeals tribunal that previously remanded such claim to the contractor" and "[u]pon receipt of such a written notice from the provider, 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 procedure." Ruing 1498-R at 20.

based on their appeal, and as a result, did not meet the requirements for remand under 1498-R. As such, this letter cannot be considered a final determination to which appeal rights to the Board attach. Rather this is a situation where the Medicare Contractor failed to follow a Board Remand Order issued pursuant to § 4.a of 1498-R and 42 C.F.R. § 405.1845(h). Accordingly, the Board hereby denies jurisdiction over the Provider's issue in the active individual appeal.

B. The Medicare Contractor Lacks Authority to Deny Jurisdiction for St. John's

CMS issued Ruling 1498-R in April 2010 for three distinct issues, one of which was the inclusion of L&D days in the Medicaid fraction.[23] The Ruling takes jurisdiction over each properly pending claim of the three issues away from the Board *but only if* such claims otherwise have satisfied the applicable jurisdictional and procedural requirements for the appeal.[24] The Ruling creates two different methods to apply the Ruling – the standard/default method and the alternative method.

The first method is the "standard" or "default" method and is laid out in § 4.a of Ruling 1498-R entitled "The Standard Implementation Procedure." Section 4.a describes the standard/default method to apply the Ruling as follows:

> Under the standard or default implementation procedure, ***the administrative tribunal*** (*i.e.*, the PRRB, the Administrator of CMS, the fiscal intermediary hearing officer, or the CMS reviewing official) ***before which the appeal is pending*** will determine whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. ***If*** *the administrative tribunal* [***i.e., the Board in this case***] *finds that the applicable jurisdictional and procedural requirements are satisfied* for a given claim on one of the three DSH issues, *then the appeals tribunal will issue a brief written order, remanding each claim that qualifies for relief under the Ruling to the appropriate Medicare contractor for recalculation of the DSH payment adjustment* (in accordance with the instructions set forth below in Section 5 of this Ruling) for the period at issue.
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> However, *if the administrative tribunal [**i.e., the Board in this case**] 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*

[23] Ruling 1498-R at 6.
[24] *Id*.

> *requirements for relief under the Ruling, then the appeals tribunal [**i.e., the Board in this case**] 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.[25]

Thus, *for this case* under the standard/default method, the Board is the administrative tribunal charged with "determin[ing] whether each claim at issue is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[26]

In recognition of the volume of cases covered by Ruling 1498-R, CMS provided for an alternative method for remand in § 4.b of Ruling 1498-R entitled "The Alternative Implementation Procedure." Significantly, § 4.b of the Ruling 1498-R specifies that ***only*** the provider may initiate the alternative method:

> Under this alternative implementation procedure, ***the hospital*** in a single provider appeal ***may submit a*** *single written* ***request*** to the pertinent administrative tribunal, requesting a remand of each and every specific claim on any of the three DSH issues for qualifying patient discharge dates and cost reporting periods (as described above in Sections 1, 2, and 3 of this Ruling) that was raised in such appeal to the appropriate Medicare contractor for implementation of the Ruling, *without the administrative tribunal* ***first determining*** whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. On remand, under this alternative procedure, *the Medicare contractor would* ***then*** *assume the responsibility for determining whether each of the provider's claims is subject to the Ruling*.
>
> The same alternative implementation procedure is available for pending group appeals on one of the three DSH issues, *provided that* ***the group's designated representative submits a*** *single written* ***request***, on behalf of every provider and for every period at issue in the group appeal, to the administrative tribunal, requesting that the entire group appeal be remanded to the appropriate Medicare contractor for implementation of the

[25] *Id*. at 17-18.
[26] *Id*. at 17.

> Ruling; *here too, the Medicare contractor*, instead of the administrative appeals tribunal, *would **then** determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines*. (However, if a provider in the group appeal were to submit a written objection to the group representative's prior request for a remand under this alternative implementation procedure, and the administrative tribunal received such written objection before it had issued a remand order under the alternative implementation procedure, then the tribunal will instead follow the standard implementation procedure (as described in Section 4.a. of this Ruling); as a result, the appeals tribunal would then determine whether each claim in the group appeal is for one of the three DSH issues and whether such claim satisfies all applicable jurisdictional and procedural requirements for relief under the Ruling.)[27]

Thus, ***if and only if*** a relevant provider or group representative specifically has requested in writing the alternative method may the Board deviate from the standard/default method and remand pursuant to the alternate method. Similarly, ***if and only if*** a provider or group representative has made a written request for the alternate method and the Board issues a remand under that method, may the relevant Medicare contractor follow the alternative procedure and "determin[e] whether each of the provider's claims is for one of the three DSH issues and whether such claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines."[28]

In this case, the record confirms that Provider did ***not*** initiate the alternate remand with a written request. Accordingly, the Board properly applied the standard/default remand method to this case. As required by Ruling 1498-R and 42 C.F.R. § 405.1840, the Board made jurisdictional and procedural findings on each of the remaining participants in Case No. 06-1065G, *including St. John's*, and found jurisdiction for all of them. Accordingly, the Board memorialized these jurisdictional finding in the 1498-R "Standard Remand" Order and remanded the remaining participants in Case No. 06-1065G (including St. John's) "to the [Medicare Contractor" for recalculation of the Providers' DSH adjustment." Significantly, the Administrator did not exercise her discretion under 42 C.F.R. § 405.1875 to review the Board's final jurisdictional determination in Case No. 06-1065G.[29] Accordingly, the Board's jurisdictional determination became the Agency's final determination.

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[27] *Id.* at 18-19 (emphasis added.)
[28] *Id*.
[29] A standard remand order under Ruling 1498-R is analogous to EJR decisions under 42 C.F.R. § 405.1875(a)(2)(3) where only the final jurisdictional decision would be reviewable by the Administrator. As such, a standard remand order would fall under § 405.1875(a)(2)(iv) and would be consistent with the example given in § 405.1875(b)(5).

The Medicare Contractor apparently mistakenly believed that the alternative method was applicable to this case when it issued its December 5, 2017 letters essentially denying jurisdiction over St. John's by asserting that the appeal to the Board was not proper under 42 C.F.R. § 405.1887. However, as noted above, the alternative method clearly does not apply to this case. As such, the Medicare Contractor did not have the authority under Ruling 1498-R to make findings of jurisdiction over St. John's or, more importantly, to either ignore or overrule the Board's finding of jurisdiction in the Board's December 9, 2013 Remand Order.

Since the Board issued its Remand Order under the standard/default remand method, if the Medicare Contractor disagreed with the Board's finding of jurisdiction over St. John's, then the Medicare Contractor should have filed its jurisdictional challenge with the Board while the appeal was still pending with the Board pursuant to Board Rules 22 and 44.4 (July 2009).[30] The Medicare Contractor had plenty of notice and opportunity in this case to do so. Further, by letter dated September 16, 2013, the Board informed the parties that the Board had initiated the 1498-R review of Case No. 06-1065GC and specifically advised the Medicare Contractor that it needed to submit any comments on jurisdiction within 30 days. However, the Medicare Contractor failed to submit any comments or specifically respond to the jurisdictional documents that the Provider submitted. Further, even after the Board issued the December 9, 2013 Remand Order, the Medicare Contractor did not, to the Board's knowledge, request that the Administrator exercise its discretion to review the Board's finding of jurisdiction in that December 9, 2013 Remand Order.

Accordingly, *the Board hereby orders the Medicare Contractor to recalculate the DSH payment adjustment for the following provider as mandated by the December 9, 2013 Board Order* pursuant the Board's authority under both the "standard or default implementation procedure" specified in § 4.a of Ruling 1498-R and 42 C.F.R. § 405.1845(h):

St. John's Reg'l Med. Ctr., Provider No. 26-0001, FYE 6/30/2004.

See also 42 C.F.R. § 405.1845(h)(3) (recognizing the Administrator's authority to review Board remand orders pursuant to § 405.1875(a)(2)(iv)). The Board recognizes that § 4.e of the Ruling addresses "Request for Review of a Finding That a Claim Is Not Subject to the Ruling" and that this section contains the statement: "Or, *if a Medicare fiscal intermediary* ***hearing officer*** *were to find,* ***under the standard implementation procedure*** (as set forth in § 4.a. of this Ruling), that a particular claim on one of the three DSH issues was not subject to the Ruling because the provider's appeal of such DSH claim did not meet a jurisdictional requirement (such as the requirement of timely filing of the provider's appeal), then the provider might request *the CMS reviewing official* to review the hearing officer's finding that the Ruling was inapplicable." CMS Ruling 1498-R at 26 (emphasis added). However, this statement is not applicable to this case because it involves a situation where the amount in controversy is less than $10,000 and the Medicare contractor *hearing officer* as part of a "contractor hearing" (*see* 42 C.F.R. §§ 405.1809 to 405.1834) is conducting the review under the alternative/default method and such "contractor hearings" are subject to review by a "CMS reviewing official" (*see* 42 C.F.R. § 405.1834).

[30] Board Rule 22 states that, in group appeals, "[t]he lead Intermediary is responsible for reviewing the Schedule of Provider and the associated jurisdictional documentation" and "[t]he lead Intermediary must forward the final Schedule of Providers with the documentation to the Board to become part of the official record along with a cover letter verifying its position that the issue is suitable for appeal and whether jurisdictional impediments exist."

If the Medicare Contractor refuses or fails to implement the Board's December 9, 2013 Order as it relates to St. John's within 30 days of the date of this letter (i.e., by Thursday, December 5, 2019), the Providers may petition the Board for a referral of this matter to CMS pursuant to 42 C.F.R. § 405.1868(c).

Board Members Participating:

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

For the Board:

11/5/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman
500 North Meridian St., Ste. 400
Indianapolis, IN 46204

RE: ***Expedited Judicial Review Determination***
Rehoboth McKinley Christian Health Care Services (Provider No. 32-0038)
FYEs: 12/31/2012, 12/31/2013, 12/31/2014
Case Nos.: 19-1218, 19-1216, 19-1215

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's September12, 2019 request for expedited judicial review ("EJR") for the appeals referenced above. On October 9, 2019, the Board notified the parties that the September 23, 2019 Medicare Administrative Contractor's jurisdictional challenge and the Provider's October 7, 2019 response to the challenge affected the 30-day period for responding to the EJR request. The Board's determination regarding jurisdiction and EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [Whether] [t]he Provider is entitled to interest by law, under the principles of equity and fairness due to the Medicare Administrative Contractor's (MAC's) and CMS's [Centers for Medicare & Medicaid Services'] erroneous determination Rehoboth was not entitled to the LVA [Low Volume Adjustment] payments.[1]

Procedural History

The Provider appealed revised NPRs that the Medicare Contractor issued on August 15, 2018 for the fiscal year ending ("FYE") 12/31/12 and on August 24, 2018 for FYEs 12/31/13 and 12/31/2014. These revised NPRs implemented August 2018 Administrative Resolutions

[1] Provider's EJR request at 1.

("2018 ARs") of the low volume adjustment ("LVA") issue. The Board assigned the Provider's appeals of the revised NPRs to the following case numbers:

Case No. 19-1218 for FYE 12/31/2012 ("FY 2012");
Case No. 19-1216 for FYE 12/31/2013 ("FY 2013"); and
Case No. 19-1215 for FYE 12/31/2014 ("FY 2014").

The Provider originally appealed the LVA issue in the following case numbers that were closed as the result of the 2018 ARs: Case No. 16-1710 for FY 2012; Case No. 17-0859 for FY 2013; and Case No. 18-1133 for FY 2014.

Provider's Request for EJR

Pursuant to 42 C.F.R. § 412.101, in order to qualify for the LVA, a provider must have sufficient evidence that: (1) it has fewer than 1,600 total discharges, and (2) it is more than 15 road miles from another subsection (d) hospital[2] under the regulation. The Provider is 64.77 miles from Cibola General Hospital, the nearest IPPS hospital. The Provider states that it had less than 1,600 discharges in each of the fiscal years under appeal. Therefore, the Provider maintains that it was eligible for a LVA in FYs 2012, 2013 and 2014.

The Provider explains that, originally, CMS determined that it was not eligible for the LVA because Gallup Indian Medical Center, which is operated by the Indian Health Service ("HIS"), was located 0.3 miles from the Provider, and CMS considered the IHS facility as a "subsection (d) hospital." However, as a result of the Provider's appeals and related efforts, CMS changed its position and, as part of the FY 2018 IPPS final rule published on August 14, 2017, CMS revised the regulations governing LVAs by adding the following new subsection (e) to 42 C.F.R. § 412.101:

> (e) *Special treatment regarding hospitals operated by the Indian Health Service (IHS) or a Tribe*. For discharges occurring in FY 2018 and subsequent fiscal years— (1) A hospital operated by the IHS or a Tribe will be considered to meet the applicable mileage criterion specified under paragraph (b)(2) of this section if it is located more than the specified number of road miles from the nearest subsection (d) hospital operated by the IHS or a Tribe.
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> (2) A hospital, other than a hospital operated by the IHS or a Tribe, will be considered to meet the applicable mileage criterion specified under paragraph (b)(2) of this section if it is located more than the specified number of road miles from the nearest

[2] 42 U.S.C. § 1395ww(d).

> subsection (d) hospital other than a subsection (d) hospital operated by the IHS or a Tribe.[3]

On March 23, 2018, Congress amended the statutory provisions governing LVAs. Specifically, in § 429 of the Consolidated Appropriations Act, 2018, Congress amended 42 U.S.C. § 1395ww(d)(12)(C) to add the following clause (iii):

> (iii) TREATMENT OF INDIAN HEALTH SERVICE AND NON-INDIAN HEALTH SERVICE FACILITIES.—For purposes of determining whether—
>
> (I) a subsection (d) hospital of the Indian Health Service (whether operated by such Service or by an Indian tribe or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act)), or
>
> (II) a subsection (d) hospital other than a hospital of the Indian Health Service meets the mileage criterion under clause (i) ***with respect to fiscal year 2011 or a succeeding fiscal year***, *the Secretary shall apply the policy described in the regulation at part 412.101(e) of title 42, Code of Federal Regulations (as in effect on March 23, 2018).*[4]

This statutory amendment in conjunction with the regulation referenced above requires CMS to exclude IHS hospitals from the mileage criteria when considering a hospital eligibility for LVA payments. Notably, the Provider points out this 2018 statutory change is retroactive back to fiscal year 2011 and states that CMS shall apply the policy to these years. The Provider's original cases were administratively resolved under these new provisions and the revised NPRs, which are the subject of this appeal, were issued.

A. Requests for Hearing and Relief Sought

In its original cases, the Provider appealed the failure of the Medicare Administrative Contractor ("MAC") to determine that the Provider was entitled to an LVA when they settled the Hospital's cost reports for FYs 2012, 2013 and 2014. The Provider explains that, although the MAC had previously determined that the Provider was entitled to a LVA for the previous FYs, CMS had instructed the MAC that an LVA should not be made based on CMS' interpretation of the LVA statute. Because the Provider did not have the funds to pay the alleged overpayment from the loss of the LVA, it obtained a bank loan in order to pay the Medicare overpayment. This loan incurred interest until it was paid back.[5]

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[3] 82 Fed. Reg. 37990, 38511 (Aug. 14, 2017).
[4] Consolidated Appropriations Act, 2018, Pub. L. No 115-141, § 429, 132 Stat. 348, 693-94 (Mar. 23, 2018) (emphasis added).
[5] Provider's Hearing at 6.

In this appeal of the revised NPRs for FYs 2012, 2013, and 2014, the Provider maintains that it is entitled to interest back to:

1. 11/25/2015 for FY 2012;[6]
2. 12/16/2016 for FY 2013;[7] and
3. 09/27/2017 for FY 2014.[8]

The Provider asserts that these are the years in which the MAC and CMS erroneously determined the Provider was not entitled to an LVA and that, as a matter of law and under the principles of equity and fairness, it is entitled to interest on the recouped and withheld LVAs.

B. Provider's Rationale for EJR

The Provider maintains that EJR is appropriate because the Board has jurisdiction over the issue and lacks the authority to grant the relief sought. The Provider maintains that the Board is unable to address the interest issue because it is based on a statutory interpretation which can only be decided by the courts. The legal question is whether CMS correctly followed the statutory requirements of 42 U.S.C. §§ 1395ddd(f)(2)(B) and 42 U.S.C. § 1395oo, or the requirements under 42 C.F.R. § 405.378.

The Provider maintains that 42 U.S.C. § 1395ddd specifically applies to the "audit of cost reports" and the Recovery of Overpayments under cost report audits and requires interest be paid. Further, 42 U.S.C. § 1395ddd(f)(2)(B) entitled "Limitation on Recoupment" requires that, if the "determination against the provider. . . is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest . . . for the period in which the amount was recouped." Under that same subsection entitled "Collection with Interest," the reverse applies as well: "[i]nsofar as the determination on such appeal is against the provider . . . interest on the overpayment shall accrue on and after the date of the original notice of overpayment." In other words, Congress recognized for purposes of imposing interest the accrual provisions would be applied to both sides. The Provider asserts that, in the years that CMS and the MAC wrongfully determined that the Provider was not entitled to the LVAs, CMS wrongfully limited the payment of interest to the Provider.

The MAC's Jurisdictional Challenges

In its jurisdictional challenges, the MAC notes that, in each case, in its original appeals,[9] the Provider appealed the disallowance of the LVA due to the proximity to an Indian Health

[6] Provider's EJR Request at 2. Review of the Board's computerized docketing system reveals that this date is the date of the Provider's original NPRs for FY 2012.
[7] Provider's EJR Request at 2. Review of the Board's computerized docketing system reveals that this date is the date of a prior revised NPR issued to the Provider for FY 2013.
[8] Provider's EJR Request at 2. Review of the Board's computerized docketing system reveals that this date is the date of the Provider's original NPRs for FY 2014.
[9] Case Nos. 16-1710 (FY 2012), 17-0859 (FY 2013) and 18-1133 (FY 2014).

Services facility. Through regulatory changes and CMS instructions, the MAC reinstated the LVA through the 2018 ARs. The terms of the 2018 ARs were implemented through reopenings and revised NPRs dated August 15, 2018 and August 24, 2018. In these cases, the Provider now claims dissatisfaction with the reopenings because they did not include a payment for interest. However, the MAC notes that the Provider did not include the payment of interest as part of the original appeals.

The MAC cites to earlier Board jurisdictional decisions involving administrative resolutions which state that issues withdrawn through an administrative resolution may not be appealed in another case because the providers agreed to all of the MAC's revisions. In the original cases, the Provider did not include a reference to the payment of interest and the MAC made no adjustment with respect to interest. The MAC cites to 42 C.F.R. § 405.1835(a)(1) for the proposition that, if a final determination is reopened under 42 C.F.R. § 405.1885, a review by the Board must be limited solely to those matters that are *specifically* revised in the MAC's revised final determination. The MAC asserts that, since there was no adjustment for interest expense, the Board lacks jurisdiction over the appeals and they should be dismissed.

Provider's Rebuttal to the Jurisdictional Challenges

The Provider counters the MAC's jurisdictional challenges by claiming the interest issue was not ripe for review when the Provider filed the original appeals of the LVA payment because payment had not yet occurred. In other words, without payment, there cannot be interest. The Provider maintains that it would have been improper to appeal interest on an unknown amount.

Further, the Provider argues that the interest issue under appeal in these cases derived *solely* from the LVA payments made as part of the 2018 ARs. The Provider maintains that the only way to properly appeal the interest issue is to cite to the adjustments from which interest originates. Since the LVA payment was withheld for a significant amount of time, the Provider contends that it is entitled to interest and its only recourse was to appeal from the payment adjustments (*i.e.*, appeal from the revised NPRs).

Decision of the Board

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

A. The Provider had no appeal rights for the interest issue under 42 C.F.R. § 405.1889.

In each of these cases, the Provider appeals a revised NPR that made adjustments to allow the LVA payment. Appeals of revised NPRs are governed by the provisions of 42 C.F.R. § 405.1889. This regulation states in relevant part that:

> (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 . . . § 405.1835 . . . 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.[10]

The $10, 000 amount in controversy requirement for Board jurisdiction has been met in each of the cases.[11]

In each of these cases, the Provider filed a timely request for a hearing within 180 days of the relevant revised NPR. However, each of these revised NPRs was a "separate and district determination[s]" that did not make any adjustment on the interest issue that the Provider appealed. The regulation, 42 C.F.R. § 405.1889 provides that an appeal of a revision to a final determination is "a separate and distinct determination" to which the provisions of 42 C.F.R. § 405.1835 apply and "only those matters that are specifically revised in a revised determination . . . are within the scope of any appeal of the revised determination." A revised NPR *neither* reopens the entire cost report to appeal *nor* extends the 180 day appeal period for any earlier NPR(s). It merely reopens those parts of the cost report adjusted by the revised NPR and *only* those adjustments may be appealed because a revised determination is "considered a separate and distinct determination." Because the interest issue was not adjusted by the revised NPR, the Board finds that it lacks jurisdiction over this issue pursuant to 42 C.F.R. § 405.1889.[12]

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[10] (Emphasis added.)
[11] *See* 42 C.F.R. § 405.1835(a)(2).
[12] *See also Franciscan St. Margaret Health v. Azar*, Case No. 18-cv-2, 2019WL4452135 (D.D.C. 2019); *HCA Health Servs. of Okla., Inc. v. Shalala*, 27 F.3d 614, 615 (D.C.Cir.1994) (The Court upheld the agency's interpretation of the its regulation to deny the Board jurisdiction over appeals from revised NPRs that raised issues that were not the "subject of the reopening.")

Moreover, the Board notes that, in order for an issue to be part of "matters that are specifically revised in a revised determination" and, thereby, be appealable to the Board, it necessarily means that the issue had to have also been covered as part of the reopening. However, it is the Board's understanding that the MAC made the reopenings underlying the revised NPRs at issue only for the purpose of implementing the 2018 ARs that the Provider and MAC had executed for FYs 2012, 2013 and 2014.[13] As such, the interest issue would not have been encompassed within the reopening,[14] much less the adjustments that were made as a result of that reopening.

Based on the above, the Board concludes that it lacks jurisdiction over the sole issue appealed in Case Nos. 19-1218, 19-1216 and 19-1215 pursuant to 42 C.F.R. § 405.1889(b) and hereby dismisses these cases.

B. In the alternative, the Board would have no jurisdiction over the interest issue.

In the alternative, even if the interest issue had not be filed from revised NPRs that did not adjust the interest issue, the Board would have lacked jurisdiction over that issue. In these cases, the Provider contends that interest on the LVA revised payment determinations is available under the provisions of 42 U.S.C. § 1395ddd(f)(2), 42 U.S.C. § 1395oo, and/or 42 C.F.R. § 405.378. However, as set forth below, none of these regulatory or statutory provisions are applicable and the Board would not have jurisdiction over issues arising from any of these provisions.

Under 42 U.S.C. § 1395ddd, after review of activities of providers of services by the qualified independent contractors ("QICs"), § 1395ddd(f)(2) provides for:

> 2) LIMITATION ON RECOUPMENT
>
> (A) IN GENERAL
>
> In the case of *a provider* of services or supplier that is determined to have received an overpayment under this subchapter and *that seeks a reconsideration by a* ***qualified independent contractor*** *on such determination* ***under section 1395ff(b)(1)*** *of this title*, the Secretary may not take any action (or authorize any other person,

[13] *See* the revised NPRs implementing the 2018 ARs. Each of the 2018 ARs is entitled "Full Administrative Resolution" and purports to "resolve the case" wherein "[t]he Provider . . . appealed the MAC's disallowance of the inpatient hospital payment for low volume hospitals." Further, under the terms of the 2018 ARs, the MAC tied the Provider's qualification for an LVA to the retroactive revisions that Congress made in March 2018 to 42 U.S.C. § 1395ww(d)(12)(C) as part of the Consolidated Appropriations Act, 2018. *See* the 2018 ARs ("On March 23, 2018, the Consolidated Appropriations Act of 2018 became Public Law No. 115-141. . . . *As a result*, . . . the MAC agrees that a low volume payment should be made." (emphasis added)).

[14] The Board is not a party to administrative resolutions (including the 2018 ARs between the Provider and the MAC) as that is solely an agreement between the parties. Further, the Provider knew of the interest issue because it was part of the damages it claimed flowed from the LVA issue as evidenced by the fact that the Provider had to take out a loan to pay back any LVA payments that it had already received for FYs 2012, 2013, and 2014 (*see supra* note 5 and accompanying text).

> including any [M]edicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1395ff(b)(1) of this title (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.
>
> (B) *COLLECTION WITH INTEREST*
>
> Insofar as *the determination on* ***such appeal*** is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.[15]

The Provider is correct that the above statutory provision addresses payment of interest for certain decisions that are later revised. However, by its terms, this statutory provision clearly applies only to decisions issued by the QIC (***not*** the Board) pursuant to 42 U.S.C. § 1395ff(b)(1). QIC decisions are not related to Medicare cost report reimbursement but rather relate to certain claims for Medicare coverage of services. Each of the revised LVA determinations at issue in these cases was not a decision issued by a QIC, rather it was issued by a MAC in order to revise the Medicare cost report following execution of an ARs by the MAC and the Provider. The Provider cited a statutory provision under which the Board does not have the authority to render a decision nor was the regulation cited the authority used by the MAC to settle the cases.

Second, the relevant part of the Board's enabling statute addressing matters that can be consider, limits Board jurisdiction to "determinations made on the Medicare cost report." Specifically, 42 U.S.C. § 1395oo states, in relevant part:

> (a) ESTABLISHMENT Any provider of services which has filed a required *cost report* within the time specified in regulations *may obtain a hearing* ***with respect to such cost report*** by a Provider Reimbursement Review Board . . . .
>
> (d) . . . . The Board shall have the power to affirm, modify, or reverse a final *determination of the fiscal intermediary* ***with respect to a cost report*** *and to make any other revisions* ***on matters***

[15] (Emphasis added.)

> ***covered by such cost report*** (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.[16]

The Board's enabling statute at § 1395oo(f)(2) does address potential annual interest due to the Provider but it is only is applicable when the Provider pursues judicial review. Specifically, § 1395oo(f)(2) permits interest to be paid where a provider seeks judicial review of a Board's decision and § 1395oo(f)(3) states that no interest awarded pursuant to paragraph (f)(2) is deemed to be income or cost for the purpose of determining reimbursement due a provider.[17] Here, in these cases, there has been no judicial review to trigger § 1395oo(f)(2) and the Board does not participate in any of the judicial review process as delineated at 42 C.F.R. § 405.1877.

Another statutory provision that addresses accrual of interest but not specifically addressed by Provider is 42 U.S.C. § 1395g(d):

> (d)ACCRUAL OF INTEREST ON BALANCE OF EXCESS OR DEFICIT NOT PAID
> *Whenever* ***a final determination*** *is made* that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, *and payment of such excess or deficit is not made* (or effected by offset) ***within 30 days of the date of the determination***, *interest shall accrue* on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

However, under this statutory provision, interest only accrues to a Provider on underpayments that are due ***pursuant to a "final determination"*** but have not been paid within 30 days of that "final determination." The Provider's interest issue does not involve interest arising from nonpayment of monies due from a final determination.[18] Rather, the Provider's interest issue involves the Provider's allegation that the original final determinations (*i.e.*, the determination issued prior to the revised determinations at issue) erroneously reversed or denied the LVA and, thereby, erroneously assessed an overpayment and that the Provider is due interest from the point in time that that erroneous determination was issued. Accordingly, § 1395g(d) by its terms is not applicable here.

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[16] 42 U.S.C. § 1395oo(d).
[17] *See also* Provider Reimbursement Manual (CMS Pub. 15-2) § 202.2 (excluded from the definition of investment income is interest earned as a result of judicial review by a Federal court).
[18] In other words, the Provider is not claiming that the MAC failed to execute the revised NPRs at issue within 30 days and that the Provider is, thereby, due interest from that point forward for nonpayment of the LVAs allowed as a result of those revised NPRs.

Moreover, any interest covered by 42 U.S.C. §§ 1395g(d) or 1395oo(f)(2) cannot be considered a matter claimed on a cost report and subsequently reviewable by the Board because that interest by its very terms is outside the cost report. In this regard, § 1395g(d) contemplates the accrual of interest only 30 days after the issuance of the final determination (*i.e.*, payment of interest 30 days after the issuance the NPR which is the final determination on the cost report). Similarly, § 1395oo(f)(3) permits the accrual of interest after judicial review of a Board decision made on an NPR.

Third, the regulation, 42 C.F.R. § 405.378 implements 42 U.S.C. §§ 1395g(d) and 1395ddd(f)(2)(B). Essentially, § 405.378 deals with interest on underpayments and overpayments in a way that mirrors the provisions of § 1395oo(f)(2) where interest would begin to accrue to the Provider 30 days following a final determination when that determination finds an underpayment but that underpayment is not made within 30 days. As such, this regulation does not allow the Board to issue a decision awarding payment of interest. Indeed, any interest would only accrue following a Board decision. Specifically, pursuant to § 405.378(i)(1), a provider must seek judicial review of a Board decision and prevail in its case:

> The provisions of this section do not apply to the time period for which interest is payable under § 413.64(j)[19] of this chapter because the provider seeks judicial review of a decision of the Provider Reimbursement Review Board, or a subsequent reversal, affirmance, or modification of that decision by the Administrator. Prior to that time, until the provider seeks judicial review, interest accrues at the rate specified in this section on outstanding unpaid balances resulting from final determinations as defined in paragraph (c) of this section.

Finally, it should be noted that the Provider would have had to have challenged the regulation at 42 C.F.R. § 405.378(h) in order to claim any *actual* interest expense associated with the funds it borrowed to repay the overpayments that were assessed. Specifically, § 405.378(h) states: "As

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[19] 42 C.F.R. § 413.64(j) states that: "Interest payments resulting from judicial review—
(1) Application. If a provider of services seeks judicial review by a Federal court (see § 405.1877 of this chapter) of a decision furnished by the Provider Reimbursement Review Board or subsequent reversal, affirmation, or modification by the Secretary, the amount of any award of such Federal court will be increased by interest payable by the party against whom the judgment is made (see § 413.153 for treatment of interest). The interest begins to accrue on the first day of the first month following the 180–day period described in § 405.1835(a)(3)(i) or (a)(3)(ii) of this chapter, as applicable.
(2) Amount due . . . 42 U.S.C. 1395oo(f), authorizes a court to award interest in favor of the prevailing party on any amount due as a result of the court's decision. If the contractor withheld any portion of the amount in controversy prior to the date the provider seeks judicial review by a Federal court, and the Medicare program is the prevailing party, interest is payable by the provider only on the amount not withheld. Similarly, if the Medicare program seeks to recover amounts previously paid to a provider, and the provider is the prevailing party, interest on the amounts previously paid to a provider is not payable by the Medicare program since that amount had been paid and is not due the provider."

specified in §§ 412.113 and 413.153 of this chapter, interest accrued on overpayments and interest on funds borrowed specifically to repay overpayments are not considered allowable costs, up to the amount of the overpayment, unless the provider had made a prior commitment to borrow funds for other purposes (for example, capital improvements)." There is no evidence the Provider attempted to claim this expense on the relevant cost report(s)[20] or to challenge this regulatory provision.

In summary, in these cases, the Provider has not referenced a statutory or regulatory provision dealing with payment of cost report interest during the pendency of a Board appeal, which is the first step in determining whether the Board might have jurisdiction over the interest issue. As noted above, the Board would not have jurisdiction over payment of the interest being claimed because this is not a matter covered by the cost report. In order to receive interest in a matter in which the a provider prevails it must: (1) first have received a final decision from the Board on a Medicare reimbursement claim, or a reversal, affirmance or modification from the Secretary of the Board's decision; (2) have sought judicial review of that decision; and (3) have been the prevailing party in the judicial action.[21] In these cases, the LVA matter was resolved through the 2018 ARs, so there is no possibility of judicial review and no interest would be owed the Provider[22] and the Board would not have the jurisdiction to award interest in the manner sought.[23]

C. Denial of EJR and Case Closure.

Since, pursuant to 42 C.F.R. § 405.1842(a), jurisdiction over an issue for which EJR is requested and the Board lacks jurisdiction over the interest issue, the Board necessarily denies Provider's request for EJR.

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[20] *See supra* note 5 and accompanying text.

[21] *See National Medical Enterprises v. Sullivan*, 960 F.2d. 866, 869 (9th Cir. 1992) ("[W] reject NME's argument that the original erroneous NPRs qualify as final determination under 42 U.S.C. § 1395g(d). . . . 42 U.S.C. § 1395g(d) . . . provides only that interest will accrue if payment of the unpaid amount is not made within 30 days of the final determination that payment is due. It does not provide for interest to accrue during the period of time it takes to determine that an error has been made. Congressional intent was not, as NME contends, that providers receive interest for the years it takes to resolve disputes over Medicare reimbursement. . . . On the facts of this case, we hold that the issuance of the revised NPRs constituted 'the final determination in question.' [citation omitted] Because the payments were made within 30 days of that final determination, NME may not obtain interest under § 1395g(d).").

[22] The Provider does not assert that the reimbursement authorized by revised NPRs was not paid within 30 days of the final determination, only that it should have been paid interest from the point in time in which CMS originally determined it was not entitled to an LVA which is the date of the issuance of the Providers original NPRs for FYs 2012 and 2014 and the date of the prior revised NPR for FY 2013. *See supra* notes 6, 7, and 8 and accompanying text.

[23] If the alternative finding of lack of jurisdiction over the interest issue were incorrect, then it is clear that the Provider would have had the right to have raised the interest issue as part of the original appeals that were otherwise resolved by the parties through the execution of the 2018 ARs. *See supra* notes 13, 14; Board Rules 7, 7.2.1.

As the interest issue is the only matter under dispute in these cases and the Board has determined that it does not have jurisdiction over the issue, the Board hereby dismisses Case Nos. 19-1218, 19-1216 and 19-1215 and closes the cases.

Review of this decision 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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

11/6/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Corinna Goron, President
Healthcare Reimbursement Services, Inc.
c/o Appeals Department
17101 Preston Road, Suite 220
Dallas, TX 75248-1372

RE: ***EJR Determination in Case No. 20-0016***
University Medical Center New Orleans (Provider No. 19-0005, FYE 6/30/2009)

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's October 10, 2019 request for expedited judicial review ("EJR") for the appeal referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in this appeal is:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[1]

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[4] These cases involve the hospital-specific DSH adjustment, which requires the

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

Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[5]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[11]

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

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[13] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

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

[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.
[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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 . . . .*[18]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[19] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C*

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

[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[19] 69 Fed. Reg. at 49099.

> *beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change 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).[22] 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."[23]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] 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.[25] However, the Secretary has not acquiesced to that decision.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 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).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d 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.").

More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] 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*.[27] 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.[28] Once again, the Secretary has not acquiesced to this decision. The Supreme Court issued a decision in *Azar v. Allina Health Services*[29] in which the Court considered whether the government had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when it posted the 2012 Medicare fractions on its website. Affirming the court of appeals finding, the Court concluded that §1395hh(a)(2) the government's action changed a substantive legal standard and, thus required notice and comment.

Provider's Request for EJR

The Provider explains that: "Because the Secretary has not acquiesced to the decision in *Allina I*, the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 Rule."[30] Accordingly, the Provider contends that the Board should grant its request for EJR.

The Provider asserts that, pursuant to 42 U.S.C. § 1395oo(f)(1), the Board must grant EJR if it lacks the authority to decide a question of "law, regulation or CMS Ruling" raised by a provider. The Provider maintains that the Board is bound by the regulation, there are not factual issues in dispute and the Board does not have the legal authority to decide the issue. Further, the Provider believes it has satisfied the jurisdictional requirements of the statute and the regulations.

Decision of the Board

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

[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).
[30] Provider's EJR Request at 1.

Jurisdiction

The Provider has filed an appeal involving fiscal year 2009.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[31] 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.[32]

On August 21, 2008, new regulations governing the Board were effective.[33] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[34] 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.[35]

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

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[31] 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.).
[32] *Bethesda*, 108 S. Ct. at 1258-59.
[33] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[34] 201 F. Supp. 3d 131 (D.D.C. 2016).
[35] *Id.* at 142.

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

Jurisdiction and EJR

The Board has determined that participant involved with the instant EJR request is governed by CMS Ruling CMS-1727-R. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[36] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeal in this EJR request involves the 2009 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[37] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which it is located.[38] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participant in this individual appeal is entitled to a hearing before the Board;

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

[36] *See* 42 C.F.R. § 405.1835(a)(2).
[37] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[38] *See* 42 U.S.C. § 1395oo(f)(1).

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

11/6/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
QRS Multicare 2013 DSH Uncompensated Care Payments CIRP Group
FYE 12/31/2013
Case No. 17-1244GC

Dear Mr. Ravindran,

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

Pertinent Facts:

The Board received the Common Issue Related Party ("CIRP") group's ("Provider" or "Providers") appeal request on March 21, 2017. The Providers are appealing Notices of Program Reimbursement ("NPRs") for fiscal year ending December 31, 2013 ("FY 2013"). The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1]

First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act. They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the 2014 decision of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*").[3] They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

[1] Group Appeal Request, Tab 2 at 1 (Mar. 21, 2017).
[2] *Id.* at 2.
[3] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Appeal Request, Tab 2 at 2-3.

Board's Decision:

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
(B) Any period selected by the Secretary for such purposes.

Further, in *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[6] the D.C. Circuit upheld a D.C. District Court decision[7] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. In its review of the District Court decision, the D.C. Circuit held that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10] Finally, it addressed the argument that the

[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 504945, 50627-28 (Aug. 19, 2013). Factor 2, for FY 2013, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[11]

In 2019, the D.C. Circuit revisited the judicial and administrative bar on review of uncompensated care DSH payments in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[12] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D.C. Circuit then applied this holding to *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for Federal FY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[13]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the

[11] *Id.* at 522.
[12] 925 F.3d 503 (D.C. Cir. 2019).
[13] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

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

For the Board:

11/6/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
John Bloom, Noridian Healthcare Solutions (J-F)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Case No. 19-0864G QRS CY 2015 DSH Uncompensated Care Distribution Pool Group
Case No. 19-1732GC Western CT Health CY 2015 DSH Uncompensated Care Distribution Pool CIRP

Dear Mr. Ravindran,

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

Pertinent Facts:

The Providers are appealing Notices of Program Reimbursement ("NPRs") for various fiscal years ending in 2015. The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1]

First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the 2014 decision of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*").[3] They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

[1] Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 4.

Board's Decision:

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
(B) Any period selected by the Secretary for such purposes.

Further, in *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[6] the D.C. Circuit upheld a D.C. District Court decision[7] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10] Finally, it addressed the argument that the

[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 504945, 50627-28 (Aug. 19, 2013). Factor 2, for FY 2014, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.
[9] *Id.* at 519.
[10] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[11]

In 2019, the D.C. Circuit revisited the judicial and administrative bar on review of uncompensated care DSH payments in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[12] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D.C. Circuit then applied this holding to *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their 2014 uncompensated care payments. As in *Tampa General*, the Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for Federal FY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[13]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the

[11] *Id.* at 522.
[12] 925 F.3d 503 (D.C. Cir. 2019).
[13] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket.

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

Board Members Participating:

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

FOR THE BOARD:

11/6/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Mark Polston
King & Spalding, LLP
1700 Pennsylvania Ave., Ste. 200
Washington, DC 20006-2706

RE: ***Jurisdictional Decision***
King & Spalding FFY 2019 Uncompensated Care Groups
FYE 9/30/2019
Cases Nos. 19-1201GC, 19-1198GC, 19-0835G

Dear Mr. Polston,

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

Pertinent Facts:

The Board received the Providers' Group Appeal Requests on January 29, 2019[1] and February 19, 2019,[2] and the Providers are appealing the final rule published in the Federal Register on August 17, 2018 for federal fiscal year 2019.

The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[3] First, the Provider claims that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[4] The Providers also claim that the statute precluding administrative and judicial review cannot shield a challenge to the procedures used in promulgating an otherwise non-challengeable rule.[5]

The Medicare Contractor filed a Jurisdictional Challenge on April 15, 2019,[6] arguing that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In support of their position, they cite to the D.C.

[1] 19-0835G.
[2] 19-1198GC & 19-1201GC.
[3] Group Appeal Request, Statement of the Issue at 1.
[4] *Id.* at 1-3.
[5] *Id.* at 3.
[6] PRRB Case No. 19-1201.

Circuit's 2016 decision in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*").[7]

On May 15, 2019, the Providers filed a Response. First, they argue that administrative a judicial review does not apply when CMS violated the APA. Since they are challenging the rulemaking process, specifically a deficient notice and comment procedure, the Providers state that the *Tampa General* case, which dealt with a challenge of data, is inapposite.[8] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the 2014 decision of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*").[9] They argue that the base year statistic used to calculate the 2019 UCC payments (2015) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2015 data since that case rendered CMS' policy regarding those days "null and void."[10]

Board's Decision:

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

(A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[11]
(B) Any period selected by the Secretary for such purposes.

Further, in *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[12] the D.C. Circuit upheld a D.C. District Court decision[13] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

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[7] 830 F.3d 515 (D.C. Cir. 2016).
[8] Providers' Jurisdictional Response at 3 (May 15, 2019) (PRRB Case 19-1201).
[9] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[10] Providers' Jurisdictional Response at 7-8.
[11] [11] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 83 Fed. Reg. at 41404. Factor 2, for FY 2019, is one (1) minus the percent change in the estimated percent of individuals who are uninsured minus 0.2 percentage points. *Id.* at 41407. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 41410.
[12] 830 F.3d 515 (D.C. Cir. 2016).
[13] 89 F. Supp. 3d 121 (D.D.C. 2015).

The District Court found that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. In its review of the District Court decision, the D.C. Circuit held that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[14] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[15]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[16] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[17]

In 2019, the D.C. Circuit revisited the judicial and administrative bar on review of uncompensated care DSH payments in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[18] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D.C. Circuit then applied this holding to *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their 2019 uncompensated care payments. As in *Tampa General*, the Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for Federal FY 2019. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the

[14] 830 F.3d 515, 517.
[15] *Id.* at 519.
[16] *Id.* at 521-22.
[17] *Id.* at 522.
[18] 925 F.3d 503 (D.C. Cir. 2019).

methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[19]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in these group appeals because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeals, the Board hereby closes them and removes them from its docket.

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

Board Members Participating:

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

For the Board:

11/6/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)
Laurie Polson, Palmetto GBA c/o National Government Services, Inc. (J-M)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephen Price, Sr., Esq.
Wyatt, Tarrant & Combs, LLP
500 West Jefferson Street, Suite 2800
Louisville, KY 40202-2898

RE: ***Expedited Judicial Review Determination***

13-1898G	Wyatt, Tarrant & Combs 2008 DSH SSI Ratio Part C Days Group
13-1901G	Wyatt, Tarrant & Combs 2008 DSH Medicaid Ratio Part C Days Group
14-2326G	KDMC/Murray Calloway 2009 DSH SSI Fraction Part C Days Group
14-2327G	KDMC/Murray-Callaway 2009 DSH Medicaid Fraction Part C Days Group
15-2310G	Wyatt 2011 DSH SSI Ratio Part C Days Group
15-2311G	Wyatt 2011 DSH Medicaid Ratio Part C Days Group
16-0059GC	Appalachian Regional Healthcare (ARH) 2012 DSH - Medicare Advantage (Part C) Days CIRP Group Appeal

Dear Mr. Price:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' September 20, 2019 (received September 23, 2019)[1] Requests for Expedited Judicial Review ("EJR") of the above referenced appeals. The Board's jurisdictional determination and decision regarding the EJR requests is set forth below.

Issue in Dispute

The relevant issue in these appeals is:

> The Fiscal Intermediary's calculation of the Providers' disproportionate patient percent, used for purposes of calculating the Medicare Disproportionate Share ("DSH") adjustment, was incorrect due to the Fiscal Intermediary Adjustment improperly excluding Medicare Advantage (Part C) days from the numerator of the Medicaid fraction and improperly including Medicare Advantage (Part C) days in the Medicare fraction used to calculate the DSH payment.[2]

[1] The Board sent a Request for Information ("RFI") to the Providers on October 8, 2019 and the Providers responded on October 22, 2019 by submitting an updated Schedule of Providers to the Board. As noted in the RFI, the RFI process affected the 30-day window for EJR review.

[2] Request for Expedited Judicial Review Determination, Issue Statement, at 1-2 (Sep. 20, 2019), 13-1898G. *See also id*. at PRRB Cases 13-1901G, 14-2326G, 14-2327G, 15-2310G, 15-2311G, 16-0059GC.

Statutory and Regulatory Background: Medicare DSH Payment

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

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.[5] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[6]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[7] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[8] The DPP is defined as the sum of two fractions expressed as percentages.[9] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[11]

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

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

> [T]he fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.[12]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[13]

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[14] 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

[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] of Health and Human Services.

> including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[15]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[16]

With the creation of Medicare Part C in 1997,[17] 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.[18]

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 . . . .*[19]

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."[20] 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*

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[15] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[16] *Id.*
[17] 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.
[18] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[19] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[20] 69 Fed. Reg. at 49099.

> *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.*[21]

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.[22] 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).[23] 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."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[25] 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.[26] However, the Secretary has not acquiesced to that decision.

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. at 47411.
[24] 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).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *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.").

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] Once again, the Secretary has not acquiesced to this decision.

The Supreme Court reviewed *Allina II* and issued a decision in *Azar v. Allina Health Services* ("*Allina III*")[30] in which the Supreme Court considered whether the Secretary had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when he posted the FFY 2012 Medicare fractions on its website. The Supreme Court affirmed the D.C. Circuit's finding and concluded that the Secretary's action changed a substantive legal standard and, thus, required notice and comment under §1395hh(a)(2). The Secretary has yet to issue any instructions to recognize or implement *Allina III*.

Providers' Request for EJR

According to the Providers, the pre-2004 standard of excluding Part C days from the Medicare fraction should be the baseline practice from which the Medicare Contractor's decision to include Part C days in the Medicare fraction is evaluated. The Providers argue that the Part C days should be excluded from the Medicare fraction and included in the Medicaid fraction.[31] The Providers continue that since the Secretary has not acquiesced to the ruling of the Supreme Court in *Allina Health Services v. Price*, 139 S. Ct. 804 (June 3, 2019) and related cases such as *Northeast Hospital Corp. v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the Board is not able to grant the relief that the Providers are seeking, thus they request that the Board grant EJR.

The Providers are also seeking interest if it is the prevailing party in any judicial review under 42 U.S.C. § 1395oo(f)(2). They recognize that the Court in *Shands Jacksonville Medical Center v. Azar*[32] found that providers that did not have a case pending on the date the rule was finalized could not be awarded interest. The Providers, who have been advised by the Medicare Contractor that they have received no instructions from the Secretary with respect to resolving the Part C issue have advised the Providers that they need to continue with the cases. Consequently, the Providers have requested EJR to resolve the interest issue. If the Secretary should acquiesce to the decision in *Allina III* before EJR is granted and suit can be filed, then the Providers request that interest be awarded under the provisions of 42 U.S.C. § 1395g(d).[33]

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[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id.* at 943.
[29] *Id.* at 943-945.
[30] 139 S.Ct. 1804 (S. Ct. 2019).
[31] Request for EJR in Case No. 13-1898G at 3 (Sep. 20, 2019).
[32] 2019 WL 1228061 (D.D.C. 2019).
[33] 42 U.S.C. § 1395g(d) states that:

> Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the

Decision of the Board

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

Jurisdiction

The participants addressed in this EJR determination have filed appeals involving fiscal years 2008-2009 and 2011-2012.

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

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extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

[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*, 108 S. Ct. at 1258-59.

[36] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

[37] 201 F. Supp. 3d 131 (D.D.C. 2016)

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]

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

The Board has determined that the participants' appeals involved with the instant EJR requests are governed by the decision in *Bethesda* and CMS-1727R. Each Provider appealed from an original NPR. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[39] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. The Jurisdictional Challenges in these cases are also governed by *Bethesda* and CMS-1727R and as such, the Board finds jurisdiction over the challenged issues. Accordingly, the Board finds that it has jurisdiction for the referenced appeals and the participants.

With respect to the Providers' request for interest if the EJR was denied, the Board notes that it need not consider the request at this time as the Secretary has not acquiesced to the Supreme Court's decision in *Allina I*, *II*, or *III*. However, if the Board were to consider the interest issue, it would be required to address: (1) whether the Providers timely raised the interest issue as part of the original appeals or timely added it to the appeals in compliance with the requirements of 42 C.F.R. § 405.1835 and (2) whether the type of interest being requested by the Providers falls outside the cost report and, hence, the jurisdiction of the Board.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the fiscal years 2008-2009 and 2011-2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being

[38] *Id.* at 142.
[39] *See* 42 C.F.R. § 405.1837.

implemented (*e.g.*, only circuit-wide versus nationwide).[40] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[41] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR.

Board's Decision Regarding the EJR

The Board finds that:

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

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

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The participants have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes those cases.

Board Members Participating:

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

For the Board:

11/15/2019

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Judith Cummings, CGS Administrators

[40] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[41] *See* 42 U.S.C. § 1395oo(f)(1).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

November 15, 2019

Brian Bodi
Director of Revenue & Reimbursement
Health First
3300 Fiske Boulevard
Rockledge, FL 32955

Geoff Pike
Appeals Coordinator
First Coast Service Options, Inc. (J-N)
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Transfer Denial - Reinstatement of Individual Appeal
Holmes Regional Medical Center
Provider Number: 10-0019
Appealed Period: FYE 09/30/2014
PRRB Case Number: 18-1044

Dear Mr. Bodi and Mr. Pike:

On November 1, 2018, Brian Bodi of Health First, authorized the transfer of the DSH SSI Percentage issue to case number 19-0179GC, the Health First CY 2014 DSH SSI Percentage CIRP Group. The individual appeal was subsequently withdrawn on November 2, 2018 because there were no remaining issues. By letter dated October 31, 2019, the Group Representative (Quality Reimbursement Services, Inc.) advised that the common issue related party (CIRP) group was now fully formed, but that it included only one participant. Since the CIRP group does not have at least two participants, the Board hereby denies the transfer of the issue to the group. The individual appeal is being reinstated and the issue will remain in case number 18-1044. A Critical Due Dates letter setting a new briefing schedule will be issued under separate cover.

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

FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Russell Kramer, Quality Reimbursement Services, Inc.

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Jacksonville, FL 32202

RE: Transfer Denial
Holmes Regional Medical Center
Provider Number: 10-0019
Appealed Period: FYE 09/30/2014
PRRB Case Number: 18-1044

Dear Mr. Bodi and Mr. Pike:

On November 1, 2018, Brian Bodi of Health First, authorized the transfer of the SSI Fraction Medicare Managed Care Part C Days issue to case number 19-0180GC, the Health First CY 2014 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group. By letter dated October 31, 2019, the Group Representative (Quality Reimbursement Services, Inc.) advised that the common issue related party (CIRP) group was now fully formed, but that it included only one participant. Since the CIRP group does not have at least two participants, the Board hereby denies the transfer of the issue to the group. The issue will remain in the individual appeal.

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

FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Russell Kramer, Quality Reporting Services, Inc.

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532 Riverside Avenue
Jacksonville, FL 32202

RE: Transfer Denial
Holmes Regional Medical Center
Provider Number: 10-0019
Appealed Period: FYE 09/30/2014
PRRB Case Number: 18-1044

Dear Mr. Bodi and Mr. Pike:

On November 1, 2018, Brian Bodi of Health First, authorized the transfer of the SSI Fraction Dual Eligible Days issue to case number 19-0181GC, the Health First CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group. By letter dated October 31, 2019, the Group Representative (Quality Reimbursement Services, Inc.) advised that the common issue related party (CIRP) group was now fully formed, but that it included only one participant. Since the CIRP group does not have at least two participants, the Board hereby denies the transfer of the issue to the group. The issue will remain in the individual appeal.

Board Members Participating:
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FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Russell Kramer, Quality Reporting Services, Inc.

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532 Riverside Avenue
Jacksonville, FL 32202

RE: Transfer Denial
Holmes Regional Medical Center
Provider Number: 10-0019
Appealed Period: FYE 09/30/2014
PRRB Case Number: 18-1044

Dear Mr. Bodi and Mr. Pike:

On November 1, 2018, Brian Bodi of Health First, authorized the transfer of the Medicaid Fraction Medicare Managed Care Part C Days issue to case number 19-0182GC, the Health First CY 2014 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group. By letter dated October 31, 2019, the Group Representative (Quality Reimbursement Services, Inc.) advised that the common issue related party (CIRP) group was now fully formed, but that it included only one participant. Since the CIRP group does not have at least two participants, the Board hereby denies the transfer of the issue to the group. The issue will remain in the individual appeal.

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

FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Russell Kramer, Quality Reporting Services, Inc.

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1508 Woodlawn Drive, Suite 100
Baltimore, MD 21207
410-786-2671

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Director of Revenue & Reimbursement
Health First
3300 Fiske Boulevard
Rockledge, FL 32955

Geoff Pike
Appeals Coordinator
First Coast Service Options, Inc. (J-N)
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: Transfer Denial
Holmes Regional Medical Center
Provider Number: 10-0019
Appealed Period: FYE 09/30/2014
PRRB Case Number: 18-1044

Dear Mr. Bodi and Mr. Pike:

On November 1, 2018, Brian Bodi of Health First, authorized the transfer of the Medicaid Fraction Dual Eligible Days issue to case number 19-0183GC, the Health First CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group. By letter dated October 31, 2019, the Group Representative (Quality Reimbursement Services, Inc.) advised that the common issue related party (CIRP) group was now fully formed, but that it included only one participant. Since the CIRP group does not have at least two participants, the Board hereby denies the transfer of the issue to the group. The issue will remain in the individual appeal.

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

FOR THE BOARD:

Charlotte F. Benson, CPA
Board Member

cc: Wilson C. Leong, Federal Specialized Services
Russell Kramer, Quality Reporting Services, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Isaac Blumberg
Chief Operating Officer
Blumberg Ribner, Inc.
11400 W. Olympic Blvd.
Suite 700
Los Angeles, CA 90064-1582

Pam VanArsdale
Appeals Lead (J-K)
National Government Services, Inc.
MP: INA 101-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: Denial of Single Participant CIRP Group
MaineHealth CY 2013 SSI Percentage CIRP Group, Case No. 19-0432GC

Dear Mr. Blumberg and Ms. VanArsdale:

The Provider Reimbursement Review Board (the Board) is in receipt of correspondence from the Blumberg Ribner, Inc. (the Representative), dated October 17, 2019, which advises that the subject group appeal is now complete (fully formed). The pertinent facts of this case and the Board's determination are set forth below.

Pertinent Facts:

On December 1, 2018, the Representative filed a request for a multi-year group appeal for the MaineHealth chain for the SSI Percentage issue which included CYs 2013 and 2014. The group was to be formed by the following transfers:

Provider	**FYE**	**From Case #**
Maine Medical Center (20-0009)	2014	17-1633
Southern Maine Health Care (20-0019)	2013	16-1163

The group appeal request did not, however, include any explanation as to why multiple years should be included in the group. Consequently, in a letter issued on December 3, 2018, the Board denied the multi-year group by denying the transfer of the 2014 provider (Maine Medical Center from case 17-1633). The group was established for calendar year (CY) 2013 only.

There were no additional participants added to the group, and on October 22, 2019, the Representative submitted a letter indicating the group appeal was fully formed.

Board Determination:

Pursuant to 42 C.F.R. § 405.1837(b), a group appeal is required to have two or more providers.[1] Since the subject group does not does not have at least two providers, it does not meet the regulatory requirements for a group appeal. Accordingly, the Board is transferring the SSI percentage issue back to the individual appeal for Southern Maine Health Care (20-0019), Case Number 16-1163. Since there are no remaining participants in the group, Case Number 19-0432GC is hereby closed.

For the Board:

11/18/2019

X Robert A. Evarts, Esq.

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

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

[1] *see* also Board Rule 12.6.1 which explains a CIRP group can be initiated by a single provider, ". . . but at least two different providers must be in the group upon full formation.")

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Joseph Willey, Esq.
Katten Muchin Rosenman, LLP
575 Madison Avenue
New York, NY 10022-2585

RE: ***Jurisdictional Decision***
NYCHHC CY 2016 Uncompensated Care Pool Factor 1 Healthy Assumption CIRP Group
FYE: Various in CY 2016
Case No.: 18-1779GC

Dear Mr. Willey,

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

Pertinent Facts:

The Providers are appealing Notices of Program Reimbursement ("NPRs") for various fiscal years ending in 2016.

The issue being appealed is related to the Disproportionate Share Hospital ("DSH") payment for uncompensated care costs ("UCC"). The Providers are challenging CMS' estimates related to an assumed expansion of Medicare and the assumption that new Medicare enrollees are healthier than the average Medicaid recipient, characterized as the "healthy assumption adjustment." The Medicare Contractor noted in its 30 Day Letter that it believes the issue is barred from administrative and judicial review per 42 U.S.C. § 1395ww(r)(3) and that a jurisdictional challenge would be forthcoming.[1] The Providers responded to that letter, generally disagreeing with the MAC's claim.[2] No Jurisdictional Challenge has been filed in this appeal.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

[1] Lead MAC 30 Day Response (Oct. 24, 2018).
[2] Response to 30 Day Letter (Nov. 20, 2018).

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[3] and
>
> (B) Any period selected by the Secretary for such purposes.[4]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[5] the D.C. Circuit Court upheld a D.C. District Court decision[6] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9] Finally, it addressed the argument that the

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[3] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[4] (Bold emphasis added and italics emphasis in original.)
[5] 830 F.3d 515 (D.C. Cir. 2016).
[6] 89 F. Supp. 3d 121 (D.D.C. 2015).
[7] 830 F.3d 515, 517.
[8] *Id.* at 519.
[9] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[10]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Providers' challenge to their UCC payments in this appeal. The Providers here are challenging their uncompensated care payment amounts by claiming that the estimates used, specifically "the actuarial assumption that the new enrollees are healthier than the average Medicaid recipient and, therefore, use fewer hospital servicers," are erroneous and lack support. The statute and regulation found at 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) specifically bar administrative and judicial review of the estimates used by the Secretary in calculating the UCC payments. Furthermore, a challenge to any underlying data (or lack of support for the data used) is barred, as well. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[12]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and

[10] *Id.* at 522.
[11] 925 F.3d 503 (D.C. Cir. 2019).
[12] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/18/2019

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
CHS CY 2016 HMA DSH Uncompensated Care Distribution Pool CIRP Group
Case No. 19-0177GC

Dear Mr. Ravindran,

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

Pertinent Facts:

The Providers are appealing Notices of Program Reimbursement ("NPRs") for various fiscal years ending in 2016. The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"). The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1]

First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the D.C. Circuit's decision in *Allina Health Servs. v. Sebelius* ("*Allina*").[3] They argue that the base year statistic used to calculate the 2016 UCC payments (2011 carried forward) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

On February 13, 2019 the Medicare Contractor filed a Jurisdictional Challenge arguing that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).[5] The Medicare Contractor also cites the D.C. Circuit Court's 2016 decision in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health*

[1] Group Issue Statement at unnumbered page 1.
[2] *Id.* at 1-2.
[3] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 3.
[5] Medicare Administrative Contractor's Jurisdictional Challenge, 3 (Feb. 13, 2019).

& Human Serv. ("*Tampa General*")[6] as additional support.[7] They ask that the Board dismiss the above referenced group appeal for lack of jurisdiction.[8]

The Providers filed a Jurisdictional Response on March 8, 2019. First, they argue that while "estimates" of the Secretary for UCC payments are shielded from review, Factor 2's data element of "the uninsured patient population percentage" is not an estimate of which the Secretary is authorized to make.[9] As a result, the Provider believes that any "estimate" of this data should be reconciled and updated with actual, accurate figures once they are available.[10] The Providers also claim that the Board has jurisdiction since federal courts can conduct a review – either in ordering mandamus relief or by invalidating the underlying regulations and policies used to calculate UCC payments.[11]

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[12] and
>
> (B) Any period selected by the Secretary for such purposes.[13]

Further, in *Tampa General*,[14] the D.C. Circuit Court upheld a D.C. District Court decision[15] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data

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[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] Medicare Administrative Contractor's Jurisdictional Challenge at 5-6.
[8] *Id.* at 6.
[9] Jurisdictional Response, 1 (Mar. 8, 2019).
[10] *Id.* at 2.
[11] *Id.* at 2-5.
[12] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.
[13] (Bold emphasis added and italics emphasis in original.)
[14] 830 F.3d 515 (D.C. Cir. 2016).
[15] 89 F. Supp. 3d 121 (D.D.C. 2015).

updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[16] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[17]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[18] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[19]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[20] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings in *Tampa General* and *DCH v. Azar* are applicable to the Providers' challenge to their FY 2016 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FY 2016. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the

[16] 830 F.3d 515, 517.
[17] *Id.* at 519.
[18] *Id.* at 521-22.
[19] *Id.* at 522.
[20] 925 F.3d 503 (D.C. Cir. 2019).

UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data used for Factor 2 should be recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review. In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[21]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/18/2019

X Clayton J. Nix

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

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Jeffery Reid
Sharp Healthcare
8695 Spectrum Center Blvd.
San Diego, CA 92123-1486

RE: ***Jurisdictional Decision***
Sharp Healthcare CY 2015 SHC F15 75% DSH Medicare Uncompensated Care CIRP Group
FYE 2015
PRRB Case: 19-1669GC

Dear Mr. Reid,

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

Pertinent Facts:

The above referenced group appeal was formed on April 11, 2018, and currently only has one Provider. The Provider is appealing a Notice of Program Reimbursement ("NPRs") for its fiscal year ending September 30, 2015. The issue being appealed is a challenge to the DSH payment for uncompensated care costs ("UCC"). The Providers argue that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1]

The issue being appealed is related to the DSH payment for uncompensated care costs ("UCC"). The Provider is challenging whether CMS correctly determined its UCC payments, and whether the statutes barring administrative and judicial review of CMS' determinations related to the factors used in calculating the UCC pool are constitutional. The Provider generally believes that data used in each factor of the UCC DSH pool contains errors, and that the best available data was not used. The Provider also generally claims that the Affordable Care Act, along with the Secretary's implementation of that Act (including the updated UCC payment formula and factors) are unconstitutional.[2]

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

[1] Group Issue Statement at unnumbered page 1.
[2] *See generally* Request for PRRB Hearing-Group Appeal (CIRP) and Statement of Issues (Apr. 11, 2018).

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[3] and
>
> (B) Any period selected by the Secretary for such purposes.[4]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[5] the D.C. Circuit Court upheld a D.C. District Court decision[6] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[7] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[8]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[9] Finally, it addressed the argument that the

---

[3] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[4] (Bold emphasis added and italics emphasis in original.)

[5] 830 F.3d 515 (D.C. Cir. 2016).

[6] 89 F. Supp. 3d 121 (D.D.C. 2015).

[7] 830 F.3d 515, 517.

[8] *Id.* at 519.

[9] *Id.* at 521-22.

estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[10]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

The Board finds that the same findings are applicable to the Provider's challenge to their FY 2015 UCC payments. The Provider here is challenging their uncompensated care payment amounts by claiming that certain data used in its calculation was understated or erroneous. They also challenge the constitutionality of the general rules used in calculating those amounts for FY 2015. *Tampa General* specifically held that the underlying data used for UCC payments cannot be reviewed or challenged. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

The Provider's claim that the UCC payment in general (as well as the Affordable Care Act) is unconstitutional does not bring their appeal within the Board's jurisdiction. Indeed, *Tampa General* rejected similar characterizations claiming to challenge the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[12] Here, the Provider has listed an amount in controversy related to its specific hospital, which they believe should be higher based on different data underlying the UCC payment calculation, or through a judicial action nullifying the underlying statutes and thus modifying the formula. Similarly, as explained in *DCH v. Azar*, the Provider is "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology."[13] In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the

[10] *Id.* at 522.
[11] 925 F.3d 503 (D.C. Cir. 2019).
[12] 830 F.3d at 521-22.
[13] *DCH v. Azar* at 508.

interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[14]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the UCC DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the UCC DSH issue is the only issue in the appeal, the Board hereby closes the referenced appeal and removes it from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/18/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***

19-2217GC Beacon Health CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP
19-2228GC Baptist Healthcare KY CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP
19-2235GC IU Health CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP Group
19-2265GC Community Health Network CY 2015 UCC Payments Using Improper S-10 Audits CIRP Group
19-2276GC Ascension Health CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP Grp
19-2280GC McLaren Health CY 2015 Uncompensated Care Payments Using Improper S-10 Audits CIRP Grp
19-2242GC Ascension Health CY 2016 Uncompensated Care Payments Using Improper S-10 Audits CIRP Grp
19-2113G Hall Render CY 2015 Uncompensated Care Payments Using Improper S-10 Audits Group

Dear Ms. O'Brien Griffin,

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

Pertinent Facts:

The Providers are appealing original or revised Notices of Program Reimbursement ("NPRs" or "RNPRs") for various fiscal years ending in calendar years ("CYs") 2015 and 2016. The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for Uncompensated Care Costs ("UCC"). Specifically, Providers are appealing the MAC's alleged failure to include appropriate costs on their S-10 worksheets for FFY 2015, which impacts their FY 2020 UCC DSH payments. They claim that their S-10's were arbitrarily audited without issuing adequate UCC reporting guidelines or going thorough adequate notice and comment requirements. They state that audits of hospitals' S-10's was inconsistent and unfair. The Providers raise several arguments about the accuracy of the S-10 data used, and the methodology in auditing those worksheets. While they acknowledge that the estimates used by the Secretary for the UCC DSH payment is not subject to review, they claim "whether the underlying data [CMS] use[s] for making their estimates is 'adequate' IS subject to review." Providers claim the disparate treatment the MAC's showed in auditing different hospitals' S-10 worksheets is unlawful and *ultra vires*, and that a statutory bar on administrative and judicial review does not extend to these types of actions. Finally, the Providers state that the D.C. Circuit held in *Allina Health Services v. Sebelius* ("*Allina*")[1] holds that "when CMS does anything affecting benefits, payment, or eligibility, it must first through [sic] the notice-and-comment requirement under the Medicare statute."[2]

[1] 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[2] Group Issue Statement.

The Medicare Contractors have filed jurisdictional challenges in two of the above referenced cases.[3] The MAC argues that, by challenging the contents of their S-10 Worksheets and the audits performed on them, the Providers are challenging the underlying data used by the Secretary in calculating the UCC DSH payments, which is precluded from review by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) and federal case law. As a result, the MACs argue that the Board lacks jurisdiction over these group appeals and that they should be dismissed.

The Providers have replied to the jurisdictional challenges,[4] and in two other cases, the MAC's filed thirty (30) day letters noting the same jurisdictional impediments.[5] The Providers filed responses to these letters, as well.[6] They argue that CMS' failure to undertake appropriate notice and comment procedures related to the S-10 audit methodology renders the resulting data inadequate, and that the bar on review does not extend to matters that violate the Medicare Statute's notice and comment requirements. They clarify that the appeals "center[] on two key agency errors: (1) CMS's failure to fulfill its requirements under the APA and Medicare Statute's notice and comment requirements; and (2) appealing a patently unlawful agency action." For support they cite a recent case, stating the following:

> The Connecticut District court recently reviewed an [Uncompensated Care] payment issue in *Yale New Haven Hospital v. Azar*[, 2019 WL 3387041 (July 25, 2019)] and applied the Supreme Court's recent ruling in *Allina*. (Exhibit P-6). In Yale New Haven, the only surviving claim stemmed from the question of:
>
> > whether the preclusion provision [of 42 U.S.C. § 1395ww(r)(3)] encompasses procedural aspects involved in the adoption of the rule that governed the determination by the Secretary of the "estimates."
>
> Despite the judicial bar in the UC DSH statute, the Court pulled from the *Allina* decision in agreeing that the Hospital's claims challenging "the procedure by which the Secretary established" a FFY 2014 policy is "separate from the substance of any such rules or policies or the determination of its estimates based on the substance of those rules or policies" and is thus not barred by judicial review.

Board's Decision:

The Board finds that it does not have jurisdiction over the Uncompensated Care DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). In this

[3] MAC's Jurisdictional Challenge (Sept. 30, 2019) (PRRB Case Nos. 19-2217GC & 19-2265GC).
[4] Providers' Response to the Medicare Administrative Contractor's Jurisdictional Challenge (Oct. 28, 2019) (PRRB Case Nos. 19-2217GC & 19-2265GC).
[5] MAC 30 Day Response Letters (Aug. 14 & 23, 2019) (PRRB Case Nos. 19-2276GC & 19-2235GC).
[6] Provider's Response to the Medicare Administrative Contractor's Rule 15.2 Letter (Sept. 13 & 20, 2019) (PRRB Case Nos. 19-2276GC & 19-2235GC).

regard, 42 C.F.R. § 412.106(g)(2) implements essentially *verbatim* the bar on certain administrative/judicial review that is delineated in 42 U.S.C. § 1395ww(r)(3):

> *Preclusion of administrative and judicial review*. There is no administrative or judicial review under sections 1869 or 1878 of the Act [*i.e.*, 42 U.S.C. §§ 1395ff or 1395oo], or otherwise, of the following:
>
> (A) **Any estimate** of the Secretary for purposes of determining the factors described in paragraph (g)(1) of this section;[7] and
>
> (B) Any period selected by the Secretary for such purposes.[8]

Further, in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.* ("*Tampa General*"),[9] the D.C. Circuit Court upheld a D.C. District Court decision[10] that there is no judicial or administrative review of UCC DSH payments. In *Tampa General*, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit affirmed the District Court's finding that there was specific language in the statute that precluded administrative or judicial review of Tampa General's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit Court went on to hold that, "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[11] The D.C. Circuit also rejected Tampa General's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[12]

The D.C. Circuit went on to address Tampa General's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was

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[7] Paragraph (g)(1) is a reference to the three factors that make up the uncompensated care payment. Factor 1 represents 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r). 78 Fed. Reg. 50495, 50627-28 (Aug. 19, 2013). Factor 2, for FYs 2014-2017, is one (1) minus the percentage of individuals under age 65 who are uninsured in 2013. *Id.* at 50631. Factor 3 is a hospital-specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with the potential to receive DSH payments relative to the estimated uncompensated care amount for all hospitals estimated to receive DSH payments in the fiscal year for which the uncompensated care payment is to be made. *Id.* at 50634.

[8] (Bold emphasis added and italics emphasis in original.)

[9] 830 F.3d 515 (D.C. Cir. 2016).

[10] 89 F. Supp. 3d 121 (D.D.C. 2015).

[11] 830 F.3d 515, 517.

[12] *Id.* at 519.

merely an attempt to undo a shielded determination.[13] Finally, it addressed the argument that the estimate made by the Secretary was *ultra vires*, or beyond the scope of statutory authority, but plainly found that "the Secretary's choice of data is not obviously beyond the terms of the statute."[14]

In 2019, the D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. V. Azar* ("*DCH v. Azar*").[15] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment, and that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself." It further stated that, allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." The D.C. Circuit recognized that it had previously held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves. The D. C. Circuit then applied this holding *DCH v. Azar* and found that the same relationship existed with regard to the methodology used to generate the estimates.

Finally the Board notes that the District Court for the District of Connecticut ("Connecticut Court") recently considered the bar on review of UCC DSH payments in *Yale New Haven Hosp. v. Azar* ("*Yale*").[16] There, the Connecticut Court dismissed all of the providers' counts in their federal complaint except one. Those that clearly sought to "undo the Secretary's estimate of its uncompensated care by recasting its challenge to that estimate as an attack on the underlying methodology" were dismissed.[17] The Connecticut Court held that the remaining count did "not challenge the Secretary's estimate of [the provider's] DSH payment, any of the underlying data, or the Secretary's choice of such data. Instead, it [was] a challenge to the procedure by which the Secretary established the" issue under appeal. The court noted that it was a close call, but there was no bar on review of "the *promulgation* of the Secretary's rules and policies, separate from the *substance* of any such rules or policies or the determination of its estimates based on the substance of those rules or policies."[18]

The Board finds that the same findings for *Tampa General* and *DCH v. Azar* are applicable to the Providers' challenge to their 2020 uncompensated care payments. The Providers are appealing from NPRs and RNPRs related to fiscal years ending in 2015 and 2016, appealing the amount of UCC DSH payments they will receive for FY 2020. The Providers claim to be challenging arbitrary and capricious or *ultra vires* actions of CMS in their failure to provide notice and receive comments on how the data for FY 2020 would be collected. It is ultimately a direct attack against the underlying methodology used to generate the Secretary's estimates for DSH purposes, which is not reviewable.[19] It is true that the

[13] *Id.* at 521-22.
[14] *Id.* at 522.
[15] 925 F.3d 503 (D.C. Cir. 2019).
[16] 2019 WL 3387041 (July 25, 2019).
[17] *Id.* at *8 (quoting *DCH v. Azar* at 508).
[18] *Id.* at *9.
[19] *DCH v. Azar* at 507.

district court case cited by the Providers[20] permitted a direct attack against a policy that failed to follow notice and comment procedures. This is because it was not a challenge to the Secretary's estimate of that hospital's payment or any specific underlying data. Here, the Providers have listed an amount in controversy related to their specific hospitals, which they believe should be higher based on different S-10 worksheet data. As in *DCH v. Azar*, they are "simply trying to undo the Secretary's estimate of [their] uncompensated care by recasting [their] challenge to that estimate as an attack on the underlying methodology."[21] In making these findings, the Board notes that, for purposes of the Board's review, the D.C. Circuit's decisions in both *Tampa General* and *DCH v. Azar* are controlling precedent for the interpretation of the statutory and regulatory provisions at issue because the Providers could bring suit in the D.C. Circuit.[22]

Based on the above analysis, the Board concludes that it does not have jurisdiction over the Uncompensated Care DSH issue in this appeal because judicial and administrative review of the calculation is barred by statute and regulation. As the Uncompensated Care DSH issue is the only issue in the appeals, the Board hereby closes the referenced appeals and removes them from its docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/18/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators
Judith Cummings, CGS Administrators
Danene Hartley, National Government Services, Inc.

[20] *Yale New Haven Hospital v. Azar*, 2019 WL 3387041 (July 25, 2019).
[21] *DCH v. Azar* at 508.
[22] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

King & Spalding, LLP
Mark Polston, Esq.
1700 Pennsylvania Avenue NW
Washington, DC 20006

First Coast Service Options, Inc.
Geoff Pike, Appeals Coordinator
Provider Audit & Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Jurisdictional Determination***
Lakeland Regional Health
FYE 9/30/07
Case No. 13-2953

Dear Messrs. Polston and Pike,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background

The Provider submitted two requests for hearing, the first on August 23, 2013 and the second on August 27, 2013, both based on a Notice of Program Reimbursement ("NPR") dated February 28, 2013. The Board combined the two requests into this one case. The case originally contained five issues, four of which have been transferred to group appeals.[1] The sole remaining issue in the case is as follows:

> Whether the Medicare Contractor used the correct Supplemental Security Income ("SSI") percentage in the DSH calculation.

Provider's Final Position Paper

On July 1, 2019, a Notice of Hearing was issued for Case No. 13-2953 setting a due date of September 18, 2019 for the Provider's Final Position Paper. The Final Position Paper for Case No. 13-2953 was received by the Board on September 17, 2019.

The Provider states that it is challenging CMS's calculation of the Provider's Medicare/SSI fraction for the fiscal year at issue. The Provider contends that CMS has miscomputed the Medicare fraction and that, therefore, the Provider's DSH payment determinations reflect significant underpayments to the Provider.[2]

[1] The Provider briefed the SSI Ratio issue and the Dual Eligible Days issue in its Final Position Paper dated September 17, 2019. The Board approved the transfer of the Dual Eligible Days Issue to PRRB Case No. 19-2398G on September 23, 2019.
[2] Provider's Final Position Paper at 1.

The Provider contends that, in CMS Ruling 1498-R, CMS alleged that it has recalculated the SSI fractions for all providers "using the same data matching process as the agency used to implement the *Baystate* decision." The Provider contends, however, that the SSI ratio component of its DSH patient percentage calculation supplied by CMS may still understate the Provider's actual SSI ratios. The Provider asserts that there are "unexplained discrepancies" and that they have been unable to verify the accuracy of the data used by CMS. In this regard, the Provider asserts that the fact that some providers have had their SSI fractions decrease as a consequence of the data match corrections is itself anomalous and suggestive of potentially continued errors in CMS's data. Therefore, the Provider contend that the SSI ratio component of its DSH patient percentage calculation supplied by CMS may continue to understate the Provider's actual SSI ratio. Without providing any additional information, the Provider asserts in its Final Position Paper that it has requested its DSH Data file from CMS in order to review the data used to calculate its SSI ratio.[3]

Medicare Contractor's Final Position Paper

The Medicare Contractor states that this appeal stems from CMS Ruling 1498-R, which relates to the data matching process. CMS ruling 1498-R provided that for qualifying appeals of the data matching issue and for cost reports not yet final settled by an initial NPR, CMS would apply any new data matching process that was adopted in the forthcoming FY 2011 IPPS final rule for each appeal that is subject to the Ruling. The Ruling further stated that, if a new data matching process was not adopted in the FY 2011 IPPS final rule, CMS would apply the same data matching process as the agency used to implement the *Baystate* decision to claims subject to the Ruling by recalculating the provider's SSI fractions. In the Final Rule, CMS also adopted the proposed data matching process for FY 2011 as final.[4]

The Medicare Contractor states that the statutory basis for the Provider to obtain the data relating to the SSI data is the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[5] Specifically, MMA § 951 directed the Secretary to begin providing hospitals the information necessary to "compute the number of patient days used in computing the disproportionate patient percentage" no later than December 8, 2004.[6]

The Medicare Contractor explains that the Secretary published her method for complying with the MMA § 951 in the August 12, 2005 Federal Register. CMS explained that:

> We interpret section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the

[3] Provider's Final Position Paper at 3 n.1 (stating simply that "[t]he Provider has requested its DSH Data File from CMS in order to review the data used to calculate its SSI ratio" without indicating when it made that request or what its status is).
[4] Medicare Contractor's Final Position Paper at 4-5.
[5] Pub. L. 108-173, 117 Stat. 2066 (2003).
[6] Medicare Contractor's Final Position Paper at 5 (quoting MMA § 951).

> Medicare and Medicaid fractions. With respect to both the Medicare and Medicaid fractions we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the [*sic*] CMS' records, and in the case of the Medicaid fraction, against the State Medicaid agency's records.

The Medicare Contractor goes on to explain that CMS stated that it calculated the Medicare fraction using data from the MedPAR Limited Data Set ("LDS") which was established in a notice published in the August 18, 2000 Federal Register. CMS determined that it would comply with MMA § 951 by releasing MedPAR LDS data to providers:

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108-173), *we will arrange to furnish*, consistent with the Privacy Act, *MedPAR LDS data for a hospital's patients eligible for both SSSI and Medicare* ***at the hospital's request***, regardless of whether there is a properly pending appeal related to DSH payments. We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the months included in the Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, the hospital will be able to use these [this] data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year. The data set made available to hospitals will be the same data set CMS uses to calculate the Medicare fractions for the Federal fiscal year.

The Medicare Contractor concludes by stating that according to CMS, the Provider requested and received MedPAR data for analysis back in December 2012.[7] Accordingly, the Medicare Contractor contends that it is unclear why the Provider has been unable to verify the data and that the Provider has not identified the source of its complaint.[8]

Board's Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841, 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

[7] Medicare Contractor's Final Position Paper at 7.
[8] *Id*.

$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.

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

> 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.[9]

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*.[10]
>
> **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,

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

> 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
>
> *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.[11]

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.

In reviewing both the Provider's original appeal request dated August 22, 2013 final position paper filed *over six years later* on September 17, 2019, the Board notes that the Provider's dispute centers around the revised data matching process adopted by CMS in the FY 2011 IPPS final rule. This revised data matching process was used in calculating the Provider's Medicare/SSI ratio for the cost report under appeal. The Provider questions the data used to calculate its SSI ratio but does not include any explanation of why the data is flawed (*i.e.*, the merits of their claim).

[11] (Italics emphasis added.)

The Board finds that the Provider failed to develop its case as required by the regulations and the Board Rules. The Provider failed to develop arguments regarding its dispute in its final position paper and only states that it has noted certain "unexplained discrepancies" and has been unable to verify the accuracy of the data used by CMS. The Provider failed to set forth the merits of its claim, explain why the agency's calculation is wrong, identify missing documents to support its claim, and explain both why these documents remain unavailable and when they will become available. The case has been pending at the Board since August 2013 and, without a good cause showing to the contrary, the Board concludes that the Provider has had adequate time to prepare its arguments.[12]

The Board finds that the Provider has essentially abandoned the appeal by filing a perfunctory position paper that did not include any discussion or analysis of the MedPAR data files that were supplied by CMS in December 2012, *nearly seven years ago, **and** prior to when the Provider filed its appeal in August 2013*.[13] As such, the Board concludes that the Provider has violated Board Rule 25.2.2 and 42 C.F.R. 405.1853(b)(2) because the Provider's final position paper did not set forth the relevant facts and arguments regarding the merits of the Provider's claims. Therefore, the Board dismisses the appeal 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.
Charlotte F. Benson, CPA
Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

11/20/2019

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

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[12] If the Provider needed more time to meet the position paper requirements, the Provider could have requested an extension. In the regard, the Board notes that Board Rule 23.5 permits parties to request extension on position paper filing deadlines: "Requests for extensions for filing a PJSO or preliminary position paper must be filed at least three weeks before the due date and will be granted *only for good cause*." (Emphasis added.) However, the Provider did not request such an extension and instead made an insufficient filing.

[13] In its Final Position Paper, the Provider asserted that it submitted a request for MedPAR information but did not provide any information on when it made this request or the status of that request. *See supra* note 3. However, the MAC states in the MAC Final Position Paper that the Provider received the requested information from CMS in December 2012. *See supra* notes 7, 8. The Provider did not file a responsive brief or otherwise contest the MAC's assertion regarding the Provider receipt of the requested information in December 2012.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Mail

Ronald S. Connelly, Esq.
Powers, Pyles, Sutter & Verville
1501 M Street, NW, 7th Floor
Washington, D.C. 20005

RE: ***EJR Determination***
Powers Pyles CY 2010 Miscalculation of DGME Cap and Weighting Factors Group
Case No. 19-2633G

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 27, 2019 request for expedited judicial review ("EJR") (received September 30, 2019) and the Providers' October 24, 2019 response to the Board's request for additional information of the same date. The decision of the Board is set forth below.

The issue for which EJR is requested is:

> . . .the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] the regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

[1] Providers' EJR request at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's

[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap,* notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap,* the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts

[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result , the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[23] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[24]

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[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).
[22] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] *Id.* at §1395(h)(4)(F)(i).

Second, the Providers posit, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 12 of the Providers' EJR request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

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

A. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[25] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[26]

[25] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[26] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[27] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[28] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The D.C. District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[29]

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

B. Jurisdiction over St. Joseph Hospital and Medical Center

a. MAC's Position

In October 1, 2019 correspondence, the MAC states that #2 St. Joseph's Hospital and Medical Center, Provider No. 31-0019 ("St. Joseph's Hospital"), filed its appeal 225 days after the issuance of its Notice of Program Reimbursement ("NPR") which is beyond the 180-day appeal period.

b. Providers' Position

The Group Representative asserts that the MAC errs in claiming the appeal for St. Joseph's Hospital was not timely filed because the MAC's focus is on the date that St Joseph's Hospital *joined* the group and not on the date of the original hearing request. The Group Representative points out that St Joseph's Hospital's individual appeal was filed on July 18, 2019, 170 days after the issuance of the Provider's NPR on January 29, 2019. Further, the Group Representative states that St Joseph's Hospital was added to Case No. 19-2633G on September 11, 2019, just 45 days after the expiration of the 180-day appeal period. Accordingly, the Group Representative maintains that St. Joseph's Hospital met the 60-day deadline to add issues after the 180-day

[27] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[28] 201 F. Supp. 3d 131 (D.D.C. 2016).
[29] *Id.* at 142.

initial filing deadline , pursuant to the regulation governing the addition of issues to a pending Board appeal, 42 C.F.R. § 405.1835(e)(3).

c. Decision of the Board with Respect to St. Joseph Hospital and Medical Center

As set forth below, the Board finds that it lacks jurisdiction over St. Joseph Hospital and dismisses St. Joseph's Hospital from the appeal. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board also denies the Provider's request for EJR.[30]

The Provider's appeal was not timely filed in this group within 180 days of the receipt of its NPR as required by 42 C.F.R. § 405.1835(a)(3) nor was the issue timely added to the individual appeal and transferred to the group appeal as permitted by 42 C.F.R. § 405.1835(c) and §§ 405.1837(b)(2)(ii) and (e)(4) and Board Rules 6.2, 16, 21.3.2, and 21.8.[31] Although 42 C.F.R. § 405.1835(e)(3) permits providers to add issues *to an individual appeal* no later than 60 days from the expiration of the 180-day appeal period (240 days after the issuance of the NPR), there is no evidence that the Provider timely and properly added the DGME issue to St. Joseph Hospital's *individual appeal* (Case No. 19-2258) and/or transferred that issue from the individual appeal to the current group. To this end, the Provider does not include documentation adding the DGME issue to the individual appeal under Tab B of the jurisdictional documents as required by 42 C.F.R. §§ 405.1835(c) and 405.1837(b)(2)(ii) and (e)(4) and Board Rule 21.3. Rather, there is only a copy of the individual appeal which does not include the DGME issue and a copy of this group appeal which includes the Provider were place under Tab B. The Group Representative's acknowledges that the Provider was included in the group case 45 days after the expiration of the 180-day appeal period and the Schedule of Providers also indicates that the Provider was directly added to the group appeal.[32]

Pursuant to 42 C.F.R. § 405.1835(a)(3), a provider has a right to a hearing with respect to a final determination if:

> . . . the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

In addition, 42 C.F.R. § 405.1835(e)(3) specifies a provider may add an issue to an individual appeal filed under § 405.1835(a) and (b) or (c) and (d):

> After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues ***to the original hearing request*** by submitting a written request to the Board only if— . . .

[30] *See* 42 C.F.R. § 405.1842(a).
[31] The Board's Rules can be found on the internet at: https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.html
[32] This was 220 days after the NPR was deemed received by the Provider pursuant to 42 C.F.R. § 405.1801(a)(iii).

> (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180–day period prescribed in paragraph (a)(3) . . . .[33]

With respect to group appeals, 42 C.F.R. § 405.1837(b)(2)(ii) permits a provider from an individual appeal to participate in a group appeal where:

> A request [for hearing] to the Board in accordance with paragraph (e)(4) of this section that a specific matter at issue in a single provider appeal, filed previously under § 405.1835 of this subpart, be transferred from the single appeal to a group appeal.

Further, 42 C.F.R. § 405.1837(e)(4), a provider may transfer an issue from an individual appeal to a group appeal.[34] This regulation states that:

> A provider may submit a request to the Board to join a group appeal any time before the Board issues one of the decisions specified in § 405.1875(a)(2). By submitting a request, the provider agrees that, if the request is granted, the provider is bound by the Board's actions and decision in the appeal. If the Board denies a request, the Board's action is without prejudice to any separate appeal the provider may bring in accordance with § 405.1811, § 405.1835, or this section. *For purposes of determining timeliness for the filing of any separate appeal and for the adding of issues to such appeal,* ***the date of receipt of the provider's request to form or join the group appeal*** *is considered the date of receipt* ***for purposes of meeting the applicable 180–day period prescribed in § 405.1835(a)(3) or § 405.1835(c)(2)***.[35]

In other words, pursuant to this regulation, a direct-add to a group appeal is treated as a separate appeal and must be filed within 180-day period prescribed in either § 405.1835(a)(3) or § 405.1835(c)(2).[36] In this regard, the Board notes that the preamble to the May 23, 2008 Final Rule addressed the exact scenario in this appeal and stated that the provider must timely add the issue to the individual appeal before transfer:

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[33] (Emphasis added.)
[34] *See also* Board Rule 4.7.3
[35] (Emphasis added).
[36] *See* 73 Fed. Reg. (May 23, 2008) (stating: "We have revised this language to state that, for purposes of determining timeliness for the filing of any separate appeal and for the adding of issues to that appeal, the date of receipt of the provider's request to form or join the group appeal is considered the date of receipt for purposes of meeting the applicable 180-day period prescribed in § 405.1835(a)(3). We were concerned that our proposal was potentially confusing and could have been disadvantageous for providers that filed the request for a group appeal hearing on or near the end of the deadline for doing so. For example, under our proposal, a provider that filed a request for a Board hearing on a group appeal on the 177th day after receiving its intermediary determination, would have only three days after the Board denied its request to join the group to file a separate appeal. Under our revision, because the provider's request for a hearing on the group appeal was timely, its subsequent request for a separate hearing also would be timely.").

> *Comment*: One commenter asked whether a provider may add an issue to a group appeal when the provider has appealed one issue of an original NPR, joined a group appeal, and is within the 60-day proposed time limit to add an issue, but is beyond 180-days from the original NPR.
>
> *Response*: We understand the commenter to be asking whether a provider, having appealed only issue A in an individual appeal, can join a group appeal that involves issue B. The answer depends on whether the provider **first (or concurrently) requests the Board to add issue B to its individual appeal** and meets the requirements for adding the issue to its individual appeal. Under § 405.1835(c) of this final rule, a provider may add an issue to its individual appeal if its request to do so meets certain requirements, including the requirement that the Board receive the request no later than 60 days after the expiration of the applicable 180-day appeal period prescribed in § 405.1835(a)(3). If the provider requests and meets the requirements for adding an issue to its individual appeal, it may also request, under § 405.1837(b)(3)(ii), that, upon addition of the issue to the individual appeal, the issue be transferred from the individual appeal to the group appeal. If the provider is beyond the time for adding an issue to its individual appeal, it may not circumvent the time limit for doing so by seeking to appeal that issue through joining a group appeal.[37]

Board Rule 6.2 is entitled "Adding a New Issue to an Individual Case" and specifies in Board Rule 6.2.1:

> [A]n issue may be added ***to an individual appeal*** if the provider:
>
> - timely files a request to the Board to add issues to an open appeal no later than 60 days after the expiration of the applicable 180 day period for filing an initial hearing request, and
>
> - includes all the supporting documentation as noted in Rule 7 [the provider must support the determination being appealed and the basis for the dissatisfaction for each issue].[38]

Board Rule 16 notes that "A provider may request to join an existing group by transferring the relevant issue from the provider's individual appeal to that group OR directly appealing *from a final determination*."[39] Board Rule 21.3.2 requires that, when filing jurisdictional documents, a

[37] (Emphasis added.)
[38] (Emphasis added.)
[39] (Underline emphasis in original and italics emphasis added.)

provider must include both the initial hearing request *and* the request to add the issue, including the issue statement in which the issue was appealed for the first time along with proof of delivery under Tab B of the jurisdictional documents. Further, Board Rule 21.8 requires the date of the transfer to the group, as well as the letter or Model Form transferring the issue from the individual appeal to the group be furnished under Tab G. This information is to be annotated on the Schedule of Providers.

St. Joseph's Hospital did not comply with the requirements to either: (a) timely and properly file the issue directly into the group appeal; or (b) timely and properly add the issue to the individual appeal and then transfer that issue to the group. Accordingly, the Board finds that it does not have jurisdiction over the Provider and dismisses it from the group appeal.

C. Multiple Issues

a. MAC's Position

The MAC contends that the group does not contain a single common issue because the issue in the initial hearing request states that the Provider appealed the question of

> Whether the [MAC] must correct its determination of the Providers' cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond their initial residency ("IRPs") used for determining payments for [DME].

In the issue statement the issue, the Providers continue by stating that, "The Providers dispute the computation of the current, prior and penultimate weighted DME FTEs and the FTE cap . . . ." The MAC posits that the current, prior and penultimate weighted FTE counts are different components of the DGME calculation and must be appealed separately.

b. Providers' Position

The Providers maintain that the issue under appeal is the validity of 42 U.S.C. § 413.79(c)(2)(iii), which the Board has already considered in other EJR determinations. The Providers explain that the DGME calculation is based, in part, on the count of FTE residents. The establishment of the proper DGME FTE count involves several factors: (1) an FTE cap established in the hospital's fiscal year end 1996; (2) weighting of resident FTEs when the residents are beyond their initial residency period; and (3) the hospital's FTE count in its current year, prior year and penultimate year all three of which are subject to the cap and weighting factors in those years.[40] The Providers contend that 42 C.F.R. § 413.79(c)(2)(iii) requires the MAC to miscalculate all of these factors in violation of the Medicare statute by determining the FYE cap after the application of the weighting factors to the resident FTE count, as it applies to all three years encompassed in a given year's DGME calculation (*i.e.*, the current, prior and penultimate years).

[40] 42 U.S.C. § 1395ww(h)(4)(C), (h)(4)(F), (h)(4)(G).

c. Decision with Respect to the Appeal of Multiple Issues

The Board finds that there is a single issue under appeal: the challenge to the validity of the regulation, 42 C.F.R. § 413.79(c)(2)(iii). The Provider is correct, a DGME calculation includes the use of all three years in the calculation for a given fiscal period and this does not constitute an appeal of multiple fiscal years or issues because the challenge to § 413.79(c)(2)(iii) is the unifying thread.

D. Board Jurisdiction over the Remaining Provider

The Board has determined that the remaining participant involved with the instant EJR request is governed by CMS Ruling CMS-1727-R since it is challenging a regulations as described more fully below. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[41] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying participant. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

E. Board's Analysis of the Appealed Issue

The Provider asserts that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Provider asserts that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Provider presents the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [42]

Accordingly, the Board set out to confirm the Provider's assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[43] As such, the equation would logically appear to be a

[41] *See* 42 C.F.R. § 405.1837.
[42] EJR Request at 4.
[43] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[44] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Provider that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[45]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[46] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[47] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the

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weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

[44] 66 Fed. Reg. at 39894 (emphasis added).

[45] (Emphasis added.)

[46] *See* 62 Fed. Reg. at 46005 (emphasis added).

[47] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

operation of the following simple algebraic principle of equivalent fractions[48] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \ c = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[49]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy

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[48] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[49] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

the remaining Provider is seeking. Consequently, EJR is appropriate for the issue under dispute in this case.

F. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the remaining participant in this appeal is entitled to a hearing before the Board;

2) Based upon the remaining participant's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the remaining Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

11/21/2019

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Judith Cummings, CGS Administrators
Wilson Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Stephen Price, Sr., Esq.
Wyatt, Tarrant & Combs, LLP
500 West Jefferson Street, Suite 2700
Louisville, KY 40202

RE: ***Expedited Judicial Review Determination***
Wyatt Part C Days Medicaid and Medicare/SSI Fraction Groups
13-1915GC ARH 2008 DSH SSI Fraction Part C Days Group
13-1917GC ARH 2008 DSH Medicaid Fraction Part C Days Group
14-2484GC ARH 2010 DSH SSI Ratio Part C Days Group
14-2485GC ARH 2010 DSH Medicaid Fraction Part C Days Group
15-1609GC ARH 2011 DSH Medicaid Fraction Part C Days Group
15-1611GC ARH 2011 DSH SSI Fraction Part C Days Group

Dear Mr. Price:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' September 19, 2019 requests for expedited judicial review ("EJR") (received September 20, 2019) and the October 29, 2019 resubmission of the Schedules of Providers and jurisdictional documents (received October 30, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

> [Whether] [t]he [Medicare Contractor's] calculation of the Providers' disproportionate patient percentage, used for the purposes of calculating the Medicare Disproportionate Share (DSH) Adjustment, was incorrect due to the [Medicare Contractor's] Adjustment improperly excluding Medicare Advantage (Part C) days from the numerator of the Medicaid fraction and improperly including Medicare Advantage (Part C) days in the Medicare fraction used to calculate the DSH payment.[1]

[1] Providers' EJR requests at 1-2.

Statutory and Regulatory Background: Medicare DSH Payment

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

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

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[10]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[11]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[12]

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[13] stated that:

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

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

> allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[14]

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

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

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the 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 . . . .*[18]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to

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[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[16] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[17] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[18] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[19] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[20]

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.[21] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change 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).[22] 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."[23]

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[19] 69 Fed. Reg. at 49099.
[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] 72 Fed. Reg. at 47411.
[23] 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).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),[24] 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.[25] However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* ("*Allina II*"),[26] 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*.[27] 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.[28] Once again, the Secretary has not acquiesced to this decision. The Supreme Court issued a decision in *Azar v. Allina Health Services* ("*Allina III*")[29] in which the Court considered whether the government had violated the 60-day notice requirement of 42 U.S.C. § 1395hh(a)(2) when it posted the 2012 Medicare fractions on its website. Affirming the court of appeals finding, the Court concluded that §1395hh(a)(2) the government's action changed a substantive legal standard and, thus required notice and comment.

Providers' Requests for EJR

In light of the Supreme Court's decision in *Allina*, the Providers contend that the pre-2004 standard of excluding Part C days from the Medicare fraction should be the baseline practice from which the decision by the Medicare Contractor to include Part C days in the Medicare fraction is evaluated. They further maintain that 42 U.S.C. § 1395hh(a)(4) should apply here with full force and that the Secretary should not be able to circumvent this requirement by claiming he was acting by way of adjudication rather than rulemaking. The statutory text says that the vacated rule may not 'take effect' at all until there has been notice and comment. The Providers assert that Part C days should be excluded from the Medicare fraction and included in the Medicaid fraction of the DSH adjustment.

[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F.3d 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.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.
[29] No. 17-1484, 2019 WL 2331304 (June 3, 2019).

The Providers are also seeking interest if it is the prevailing party in any judicial review under 42 U.S.C. § 1395oo(f)(2). They recognize that the Court in *Shands Jacksonville Medical Center v. Azar*[30] found that providers that did not have a case pending on the date the rule was finalized could not be awarded interest. The Providers, who have been advised by the Medicare Contractor that they have received no instructions from the Secretary with respect to resolving the Part C issue have advised the Providers that they need to continue with the cases. Consequently, the Providers have requested EJR to resolve the interest issue. If the Secretary should acquiesce to the decision in *Allina* before EJR is granted and suit can be filed, then the Providers request that interest be awarded under the provisions of 42 U.S.C. § 1395g(d).[31]

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2008, 2010 and 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[32] In that case, the Supreme Court concluded that a cost

[30] 2019 WL 1228061 (D.D.C. 2019).
[31] 42 U.S.C. § 1395g(d) states that:

> Whenever a final determination is made that the amount of payment made under this part to a provider of services was in excess of or less than the amount of payment that is due, and payment of such excess or deficit is not made (or effected by offset) within 30 days of the date of the determination, interest shall accrue on the balance of such excess or deficit not paid or offset (to the extent that the balance is owed by or owing to the provider) at a rate determined in accordance with the regulations of the Secretary of the Treasury applicable to charges for late payments.

[32] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).

report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[33]

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

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

The Board has determined that the participants involved with the instant EJR requests are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[37] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[33] *Bethesda,* 108 S. Ct. at 1258-59.
[34] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[35] 201 F. Supp. 3d 131 (D.D.C. 2016).
[36] *Id.* at 142.
[37] *See* 42 C.F.R. § 405.1837.

With respect to the Providers' request for interest if the EJR was denied,[38] the Board notes that it need not consider the request at this time as the Secretary has not acquiesced to any of the decisions in *Allina I, II, or III*. However, if the Board were to consider the interest issue, it would be required to address: (1) whether the Providers timely raised the interest issue as part of the original appeals or timely added it to the appeals in compliance with the requirements of 42 C.F.R. § 405.1835 and (2) whether the type of interest being requested by the Providers falls outside the cost report and, hence, the jurisdiction of the Board.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2008, 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[39] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[40] Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

[38] EJR request 3-6.
[39] *See generally Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[40] *See* 42 U.S.C. § 1395oo(f)(1).

4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

11/22/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Strategic Reimbursement Group, LLC
Ken Janowski, Vice President
16408 E. Jacklin Dr.
Fountain Hills, AZ 85268

Noridian Healthcare Solutions
c/o Cahaba Safeguard Administrators
Lorraine Frewert
P.O. Box 6782
Fargo, ND 58108-6782

RE: *Jurisdictional Decision and Remand Order*
St. Helena Hospital (Provider No. 05-0013)
FYE 12/31/2009
Case No. 14-1456

Dear Mr. Janowski and Ms. Frewert,

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, the Parties' positions and the Board's jurisdictional determination are set forth below.

Pertinent Facts

On June 26, 2013, the Medicare Contractor issued a Notice of Program Reimbursement ("NPR") for the Provider's fiscal year end ("FYE") 12/31/2009. On December 19, 2013, the Provider timely filed an appeal request with the Board for the following nine issues:

(1) DSH Medicaid Eligible days (Transferred to Case No. 14-3841GC)
(2) DSH Part C days (Transferred to Case No. 14-3842GC)
(3) DSH Dual Eligible Days (Transferred to Case No. 14-3843GC)
(4) DSH non-code 1 Days (Transferred to Case No. 14-3844GC)
(5) Bad Debts – Must Bill (*Withdrawn* on June 18, 2018)
(6) Bad Debts – Crossover (*Withdrawn* on October 7, 2019)
(7) Bad Debts – Charity Care (*Withdrawn* on March 22, 2019)
(8) Bad Debts – non Crossover (*Withdrawn* on March 22, 2019)
(9) DSH Labor and Delivery Room ("LDR") Days

As shown above, following a number of transfers and withdrawals, the sole remaining issue in this appeal is Issue 9. The Provider's appeal request described Issue 9 as: "Whether the Intermediary's adjustment numbers 22 and 25, exclusion of labor room days from total and Medi-Cal days in the ratio of Medicaid utilization in the computation of Disproportionate Share settlement, are consistent with Medicare policy as stated in Program Memorandum No. A-85-12 dated November 1985 and Ruling No. CMS-1498-R dated April 28, 2010."

The Medicare Contractor filed a jurisdictional challenge with the Board on March 20, 2015 for issues 1 through 4 and issue 9.[1] The Medicare Contractor then withdrew its jurisdictional challenge for issues 1 through 4 in its Final Position Paper (August 30, 2018). The Provider's Jurisdictional Challenge Response was submitted on July 24, 2019.[2] As a result, the Board's ruling only addresses Issue 9 which the Provider described as follows in its appeal request filed with the Board on December 19, 2013:

> Issue #9: Whether the Intermediary's adjustment numbers 22 and 25, the exclusion of labor room days from total and Medi-Cal days in the ratio of Medicaid utilization in the computation of Disproportionate Share settlement, are consistent with Medicare policy as stated in Program Memorandum No. A-85-12 dated November 1985 and Ruling CMS-1498-R dated April 28, 2010.

In its preliminary position paper filed with the Board on August 6, 2014, the Provider restates Issue #9 in two separate places as follows:

> Issue #9: Whether the Intermediary's adjustment numbers 22 and 25, the exclusion of Medicaid and total labor room days in the Medicaid ratio of the Disproportionate Share calculation, are appropriate.[3]

> Issue 9: Whether the Intermediary's adjustment numbers 22 and 25, the exclusion of labor room days in the Medicaid patient utilization percentage used to complete the patient DSH percentage in the disproportionate share settlement, are consistent with 42 CFR Regulation §412.106, Provider Reimbursement Manual Instructions and in accordance with Ruling Number CMS-1498-R dated April 28, 2010.[4]

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor argues that the Board does not have jurisdiction over DSH LDR Days issue because it did not make an adjustment to the cost report for the issue and that, therefore, the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. The Medicare Contractor

[1] Medicare Contractor's jurisdictional challenge (March 20, 2015).
[2] Provider's Jurisdictional Response (July 24, 2019). Note: the Provider addresses issues 2, 4 and 9 in its response. However, the Medicare Contractor withdrew its jurisdictional challenge over issues 2 and 4 in its Final Position Paper therefore the Board will not address these issues.
[3] Provider's Preliminary Position Paper at 2.
[4] *Id.* at 11.

goes on to explain that the Provider has not shown how these days were reported or presented on the cost report and disallowed by the Medicare Contractor.[5]

The Medicare Contractor states that the Provider contends that the Board should remand the Labor and Delivery Room issue to the Medicare Contractor pursuant to CMS Ruling 1498-R. The Medicare Contractor argues that remand of this issue is not appropriate since this appeal was not pending before the Board as of April 28, 2010.[6]

Provider's Jurisdictional Challenge Response

The Provider contends that it has "been a long-standing CMS policy and CMS directives to the MAC's that labor room days should be excluded in the Medicaid ratio." The Provider filed its Medicare cost report in May 2010 and believed it was "fruitless" to spend additional legal fees in pursuing the issue of labor room days.[7] The Provider recognized the applicability of CMS Ruling 1498-R by stating that "[s]ubsequent to the filing of the cost report and prior to the filing of the appeal request it was discovered that CMS directed the MAC to finally allow labor room days in the Medicaid ratio in the DSH reimbursement computation" and that, "[t]herefore, the MAC should have included an adjustment to include labor room days in the Medicaid ratio in the DSH reimbursement per the CMS directive during their cost report review prior to the release of the NPR."[8]

Finally, the Provider argues that CMS-1727-R applies to the subject appeal since the fiscal year is December 31, 2009 and the Provider acted in good faith effort due to prior years' disallowance of the labor room days from the Medicaid ratio. Therefore, the self-disallowance should be waived and the Board should have jurisdiction over this issue.[9]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction and whether remand is appropriate under CMS Ruling 1498-R. Regulation dictates that a provider must preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either:

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[5] Medicare Contractor's jurisdictional challenge at 15 (March 20, 2015).
[6] *Id*. at 32.
[7] Provider's Jurisdictional Response at 9 (July 24, 2019).
[8] *Id.*
[9] *Id.* at 9-10.

> (i) Including a claim for the specific item(s) on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or
>
> (ii) Effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item(s) by following the applicable procedures for filing a cost report under protest, where the provider seeks payment that it believes may not be allowable or may not be in accordance with Medicare policy[10]

However, recent developments have modified the application of this regulation.

In *Banner Heart Hospital v. Burwell* ("*Banner*"), the District Court for the District of Columbia ("D.C. District Court") held that a provider cannot be held to the claim preservation/presentment requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy).[11] The D.C. District Court explained its decision as:

> [W]hen a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].[12]

The D.C. District Court looked to *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) (*"Bethesda")* which also addressed a challenge to a regulation which was not first presented to the Medicare contractor. *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling.[13] The Supreme Court in *Bethesda* stated:

> [T]he 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

[10] 42 C.F.R. 405.1835(a)(1)(2013).
[11] 201 F. Supp. 3d 131 (D.D.C. 2016).
[12] *Banner* at 141.
[13] *Bethesda* at 404.

> the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.[14]

Subsequent to *Banner*, CMS issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to largely follow the holding in *Banner*. Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a Board hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[15]

A. Analysis of the DSH Labor and Delivery Room Days Under Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 28, 2018. In the instant case, the Board received the Provider's request for hearing on December 18, 2013 and the appeal was open on December 19, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end December 31, 2009 cost report, thus the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was 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 the provider."[16] The Board looks to step two if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, *i.e.*, an "allowable" item. In the instant appeal, CMS Ruling 1498-R gave the Medicare Contractor certain payment authority to resolve issues regarding the inclusion of Labor and Delivery Room Days in the DSH calculation for both properly *pending* appeals and *open* cost reports if they were for reporting periods beginning prior to October 1, 2019. Notwithstanding, it is clear that, for the time period at issue, this Ruling did not modify CMS' official policy which per 42 C.F.R. § 412.106 specified that LDR inpatient days are not included in DSH calculations for reporting periods covered by this Ruling (*i.e.*,

[14] *Id.*
[15] Ruling 1727 at unnumbered page 2
[16] Ruling 1727 at 6.

reporting periods beginning prior to October 1, 2009).[17] Moreover, CMS issued this Ruling *only a month before* the Provider filed the Medicare cost report at issue without changing CMS' official policy and, as such, the Provider had a reasonable belief that the appealed items was subject to a regulation that bound the Medicare contractor and left it with no authority to make the payment sought by the Provider. More specifically, CMS Ruling 1498-R is directed to the Medicare Contractors (not Providers) on how to handle "resolution" of certain pending appeals and open cost reports involving Labor and Delivery Room days and did ***not*** change or otherwise alter existing CMS policy on how Labor and Delivery Room days are to be reported on the cost report during the time at issue.[18] In fact, CMS did not change its regulation governing LDR days until the FY 2009 IPPS final rule published on August 27, 2009 and that change was effective only prospectively for cost reporting periods *beginning **on** or **after** October 1, 2009*.[19] Accordingly, the Board finds that the second step of Ruling 1727 is met.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in the applicable regulation.[20] As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made under step two that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought at the time the Provider prepared its cost report. As discussed *supra*, the Boar found that the issue under appeal met step two.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. In the instant appeal, however, the Provider did not self-disallow the Labor and Delivery Room Days issue, thus this step is not applicable to this appeal.

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[17] 74 Fed. Reg. 43754, 43899 (Aug. 27, 2008) (stating at 43899 "Under the existing regulations at § 412.106(a)(1)(ii)(B), patient days associated with beds used for ancillary labor and delivery are excluded from the Medicare DSH calculation."; and at 43901 "After consideration of the public comments received, we are finalizing our proposed policy, without modification, to include patient days associated with patients occupying labor and delivery beds in the disproportionate patient percentage of the Medicare DSH adjustment *for cost reporting periods beginning on or after **October 1, 2009***, under § 412.106(a)(1)(ii)." (emphasis added)).

[18] *See* CMS Ruling 1498-R at 14-15; 74 Fed. Reg. 43754, 43499-501 (Aug. 27, 2009) (reaffirming DSH L&D days policy for periods prior to October 1, 2009).

[19] *See supra* note 17.

[20] 42 C.F.R. § 405.1835(a) (2010).

B. Analysis of the DSH Labor and Delivery Room Days Under CMS Ruling 1498-R

On April 28, 2010, CMS issued CMS Ruling 1498-R that addresses three Medicare DSH issues, including the Exclusion of LDR Inpatient Days from the disproportionate patient percentage ("DPP"). With respect to the Exclusion of LDR Inpatient Days issue, CMS Ruling 1498-R requires an administrative appeals tribunal (in this case, the Board) to remand each *qualifying* provider appeal to the appropriate Medicare contractor in order to recalculate the provider's DSH payment adjustment according to the specific mandates set out in CMS Ruling 1498-R. As such, in order for the Board to remand the Provider's LDR Days pursuant to CMS Ruling 1498-R, the Provider must have an appeal that otherwise *qualifies* for remand.

CMS Ruling 1498-R requires the Board to remand cost reporting periods beginning before October 1, 2009 for the LDR day issue and the directive to remand appears to be limited to *then **pending** appeals*:

> In accordance with the foregoing history and determination, CMS and the Medicare contractors will resolve *each properly **pending** claim*, in a DSH appeal for a cost reporting period beginning before October 1, 2009, in which the hospital seeks inclusion in the DPP of LDR inpatient days. *For such properly **pending** appeals*, CMS and the contractors will recalculate the hospital's DSH payment adjustment for the period at issue by including the LDR days in the Medicaid fraction or the SSI fraction (whichever proves to be applicable), regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. This resolution of *properly **pending** appeals*, for pre-October 1, 2009 cost reporting periods, comports with CMS' view that LDR inpatient days belong in the DPP if such days satisfy the requirements for inclusion in the Medicaid fraction or the SSI fraction, regardless of whether the LDR patient had occupied a routine care bed prior to occupying an ancillary LDR bed before the census-taking hour. CMS' action eliminates any actual case or controversy regarding the hospital's previously calculated DSH payment adjustment and thereby renders moot *each properly **pending** claim* in a DSH appeal, for a pre-October 1, 2009 cost reporting period, in which the hospital seeks inclusion in the DPP of LDR inpatient days, provided that the disputed LDR inpatient days otherwise meet the requirements for inclusion in the Medicaid fraction or the SSI fraction and the claim satisfies the applicable jurisdictional and procedural requirements of section 1878 of the Act, the Medicare regulations, and other agency rules and guidelines. Accordingly, it is hereby held that the PRRB and the other administrative tribunals lack

> jurisdiction over *each properly **pending** claim* on the LDR inpatient day issue for a cost reporting period beginning before October 1, 2009, provided that such claim otherwise satisfies the applicable jurisdictional and procedural requirements for appeal.
>
> As explained below in Sections 4 and 5 of this Ruling, CMS and the Medicare contractors will take the steps necessary to include LDR inpatient days in the DPP (to the extent that a given LDR inpatient day otherwise meets the requirements for inclusion in the Medicaid fraction or the SSI fraction), and to recalculate the DSH payment adjustment, *for each properly **pending** claim* on the LDR inpatient day issue for a pre-October 1, 2009 cost reporting period that is remanded by an administrative appeals tribunal and is found to qualify for relief under this Ruling.

It is clear that, the FY 2009 cost report at issue was not settled at the time CMS issued CMS Ruling 1498-R (it was not filed until 1 month after the Ruling was issued) and, as such, that the Provider did not have an appeal *pending* at the time CMS issued CMS Ruling 1498-R. Accordingly, the above directive in CMS Ruling 1498-R is not applicable in this case.

Notwithstanding, CMS Ruling 1498-R have another directive that applies to reporting periods beginning before October 1, 2009 such as the cost report at issue which began on January 1, 2009. Specifically, the Ruling applies to cost reporting periods that began before October 1, 2009 and were open (*i.e.*, were not otherwise settled) as of the issuance of CMS Ruling 1498-R on April 28, 2010:

> [I]n order to avoid, or at least minimize, the filing of new DSH administrative appeals on the LDR inpatient day issue, CMS and the Medicare contractors ***will ensure*** *that a hospital's LDR inpatient days are included in the Medicaid fraction or the SSI fraction* (whichever proves to be applicable), in calculating the DSH payment adjustment ***for each open cost report*** *for a pre-October 1, 2009 cost reporting period where the contractor has not yet settled finally the provider's Medicare cost report through the issuance of an initial NPR*, see 42 C.F.R. §§ 405.1801(a), 405.1803. For properly pending DSH appeals on the LDR inpatient day issue and ***for qualifying open cost reports***, and to the extent that the disputed LDR days were for patients who were entitled to Part A benefits (as described in Section 2 of this Ruling), ***CMS will account for such LDR days*** *in the determination of the SSI fraction, by including those days in the same suitably revised data matching process* (as set forth in Section 5.a. of this Ruling) that

> the agency will use to match Medicare and SSI eligibility data in determining the hospital's SSI fraction for the period at issue.[21]

The second directive in the Ruling is clear that "Medicare contactors ***will ensure*** that a hospital LDR inpatient days are include in the Medicaid fraction or SSI fraction (whichever proves to be applicable), in calculation the DSH payment adjustment *for each* ***open*** *cost report* for a pre-October 1, 2009 cost reporting period." Finally, the record in this case is also clear that the Medicare Contractor failed to follow this second directive in the Ruling and review or include any of the LDR days at issue in the DSH calculation when it settled the Provider's FY 2009 cost report.

C. *Summary and Remand Order*

Pursuant to CMS-1727-R, the Board finds jurisdiction over the sole remaining issue in this case, the LDR days issue, because: (1) CMS Ruling 1498-R is directed to the Medicare Contractors (not Providers) on how to handle "resolution" of certain pending appeals involving Labor and Delivery Room days; (2) while CMS instructed Medicare contractors on how to resolve pending appeals and open cost reports with the LDR days DSH issue for cost reporting periods beginning prior to October 1, 2009, CMS Ruling 1498-R did ***not*** otherwise change or alter existing CMS policy on how LDR days are to be reported on the cost report during the time at issue; and (3) the revision to 42 C.F.R. § 412.106 that allowed LDR days was not effective until October 1, 2009.

The Board's governing regulations at 42 C.F.R. § 405.1845(h) allow the Board to issue a remand order to the Medicare Contractor as follows:

> (h) Remands.
>
> (1) Except as provided in paragraph (h)(3) of this section, a Board remand order may be reviewed solely during the course of Administrator review of one of the Board decisions specified in § 405.1875(a)(2) of this subpart), or of judicial review of a final agency decision as described in § 405.1877(a) and (c)(3) of this part, as applicable.
>
> (2) The Board may order a remand requiring specific actions of a party to the appeal. In ordering a remand, the Board must -
>
> (i) Specify any actions required of the party and explain the factual and legal basis for ordering a remand;
>
> (ii) Issue the remand order in writing; and

[21] *See* CMS Ruling 1498-R at 16-17 (emphasis added).

> (iii) Mail the remand order promptly to the parties and any affected nonparty, such as CMS, to the appeal.
>
> (3) A Board remand order is not subject to immediate Administrator review unless the Administrator determines that the remand order might otherwise evade his or her review (as described in § 405.1875(a)(2)(iv) of this subpart).

In exercising its authority under § 405.1845(h),[22] the Board makes the following findings based on its previous analysis of the facts and law:

1. CMS Ruling 1498-R directed the Board to remand any appeals that were ***pending*** on April 28, 2010 (*i.e.*, the date the ruling was issued) if the appeal included the LDR days DSH issue and pertained to a cost report with a reporting period beginning before October 1, 2009.

2. CMS Ruling 1498-R directed the Medicare Contractor to include LDR days in the DSH calculation for any cost reports with reporting periods beginning before October 1, 2009 that were ***open*** (*i.e.*, were not otherwise settled) on April 28, 2010.

3. The cost report at issue cost involved a reporting period beginning before October 1, 2009 and was open when CMS issued CMS Ruling 1498-R.

4. Contrary to the directive in CMS Ruling 1498-R, the Medicare Contractor did not include any of the LDR days at issue in the Provider's DSH calculation for FYE 12/31/2009.

5. As part of its appeal request and its response to the Medicare Contractor's jurisdictional challenge, the Provider has maintained that CMS Ruling 1498-R is applicable to this appeal and includes a directive that the LDR days at issue be included in its DSH calculation.

6. With respect to CMS Ruling 1498-R, the Board finds that, while the CMS Ruling 1498-R directive in Finding No. 1 is not applicable, the CMS Ruling 1498-R directive stated in Finding No. 2 is applicable.

Accordingly, pursuant to its authority under 42 C.F.R. § 405.1845(h), the Board hereby remands the LDR days issue to the Medicare Contractor to review and audit the LDR days at issue for the FYE December 31, 2009 and, consistent with the directive in CMS Ruling 1498-R, include LDR days, as appropriate, in the Provider's DSH calculation for FYE December 31, 2009. As this was the sole remaining issue in Case No. 14-1456, the Board closes it and removes it from the Board's docket.

[22] *See also* 42 C.F.R. § 405.1871(b)(5).

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

For the Board:

11/22/2019

X Clayton J. Nix

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

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