DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Lisa Ellis
Toyon Associates, Inc.
1800 Sutter St., Ste. 600
Concord, CA 94520

RE: ***Jurisdictional Decision***
Stanford Health Care (Prov. No. 05-0441)
FYE 08/31/2007
Case No. 19-2373

Dear Ms. Ellis,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced individual appeal and finds that it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio issue. Similarly, the Board finds that it does not have jurisdiction over the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

In a reopening request filed with the Medicare Contractor on June 7, 2018, the Provider requested "a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."[1] The Medicare Contractor's Notice of Reopening was issued on August 7, 2018 and confirmed that the cost report was being reopened to adjust the SSI ratio based on the hospital's cost reporting period rather than the federal fiscal year.

On February 21, 2019, the Provider was issued a revised Notice of Program Reimbursement ("NPR") for fiscal year end August 31, 2007.

On August 8, 2019, the Board received the Provider's individual appeal request. The Individual Appeal Request contained two (2) issues:

1. Medicare Disproportionate Share Hospital (DSH) Payments – Accuracy of CMS Developed SSI Ratio
2. Medicare Disproportionate Share Hospital (DSH) Payments – Inclusion of Medicare Part C Days in the SSI Ratio

[1] Toyon Cost Report Reopening & SSI Realignment Request at 1 (June 7, 2018).

The Board received a Jurisdictional Challenge filed on behalf of the Medicare Administrative Contractor ("MAC") on September 11, 2020, which argued that the Board lacks jurisdiction of the appeal issues "because the issues in dispute were not adjusted for the RNPR."[2]

The Board received a Jurisdictional Response on October 7, 2020, which contended that the Board should find jurisdiction over PRRB Case Number 19-2373 because the Provider argues the fractions ". . . were specifically adjusted in the RNPR, and Provider has the right to appeal them as such, pursuant to 42 C.F.R. § 405.1889."[3]

Board's Decision:

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

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

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

[2] Medicare Administrative Contractor Jurisdictional Challenge at 3 (Sept. 11, 2020).
[3] Toyon Jurisdictional Response at 5 (October 7, 2020).

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

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

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

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

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

Stanford Health Care requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. The Notice of Reopening clearly states that the purposes of the reopening was to "To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." To this end, the audit adjustments associated with the revised NPR under appeal clearly (Adjustment Nos. 4 and 6) only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. To this end, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. When CMS performs the realignment process, it does not utilize a new or different data match process when it issues a realigned SSI percentage and, in particular, does not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[4] Rather, it is simply that a

[4] CMS does not utilize a new or different data match process when it issues a realigned SSI percentage. CMS describes the matching process that it uses as part of the FY 2011 IPPS final rule published on August 16, 2010. *See* 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010). All of the underlying data which is gathered on a month-by-month basis remains the same and the realigned SSI percentage simply reflects a different 12-month time period being used. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis). The realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's

different 12-month time period is used. Since the revised NPR for Sanford Health Care did not adjust the Part C days issue or the SSI accuracy issue (which in part entails allegations of flaws and inaccuracies in CMS' matching process of patient records with SSA records) as required by 42 C.F.R. § 405.1889, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal the revised NPR for both issues and that, as a result, the Board lacks jurisdiction over both issues in the appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[5] Accordingly, the Board hereby, dismisses the case and, since 42 C.F.R. § 405.1842(f) specifies that jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board also denies the Provider's request for EJR of the Part C Days issue.

Finally, the Board notes the Provider is not harmed by this dismissal since it already has previously appealed these issues from its original NPR for the same FYE and subsequently transferred the issues to group cases (Case Nos. 17-1393G and 17-1397G). Moreover, the Board already granted Expedited Judicial Review ("EJR") in the Part C days group case (17-1397G) on June 6, 2019. In this regard, Board Rule 4.6.2 specifies that "[a]ppeals of the same issue from distinct determinations must be pursued in a single appeal." As such, even if the Board were to have jurisdiction over the revised NPR, the Provider would be prohibited from pursuing the Part C days issue as appealed from the revised NPR since the group case to which the Provider had transferred the Part C days issue appealed from the original NPR is no longer pending before the Board due to the Board's grant of EJR (*i.e.*, the Provider would not be able to consolidate its current appeal with its previous appeal of the ***same*** issue).

Conclusion

The Board dismisses the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues appealed form the revised NPR issued for Stanford Health Care for FYE 08/31/2007 because the issues were not specifically adjusted in the revised NPR and because the Part C days issue was previously appealed from the original NPR for which the Board has already granted EJR. Since there are no other issues pending for the revised NPR appeal for Stanford Health Care, the Board closes Case No. 19-2373 and removes it from the Board's docket.

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cost reporting period instead of the September 30 FFY. *See also* 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

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

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

Board Members Participating:

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

For the Board:

12/2/2020

Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Mridula Bhatnagar
Toyon Associates, Inc.
1800 Sutter Street
Concord, CA 94520

RE: ***Jurisdictional Decision***
Washington Hospital (Prov. No. 05-0195)
FYE 06/30/2015
Case No. 20-1274

Dear Ms. Bhatnagar,

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 Accuracy of CMS Developed SSI Ratio issue. The Board also finds that it does not have jurisdiction over the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

In a reopening request filed with the Medicare Contractor on January 7, 2019, the Provider requested "a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."[1] The Medicare Contractor's Notice of Reopening was issued on March 1, 2019, and confirmed that the cost report was being reopened to adjust the SSI ratio based on the hospital's cost reporting period rather than the federal fiscal year.

On September 3, 2019, the Provider was issued a revised Notice of Program Reimbursement ("NPR") for Fiscal Year end June 30, 2015.

On February 27, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained two (2) issues:

1. Accuracy of CMS Developed SSI Ratio
2. DSH Inclusion of Medicare Part C Days in the SSI Ratio

In correspondence filed on October 13, 2020, the Provider requested the transfer of the Accuracy of CMS Developed SSI Ratio issue from the individual appeal to a group appeal, Case No. 20-1587G.

[1] Toyon Cost Report Reopening & SSI Realignment Request at 1 (Jan. 7, 2019).

Board's Decision:

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

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

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

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

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

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

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

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

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

Washington Hospital requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. The Notice of Reopening clearly states that the purposes of the reopening was to "To adjust the SSI ratio used to calculate the provider's disproportionate share adjustment based on data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio." To this end, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. When CMS performs the realignment process, it does not utilize a new or different data match process when it issues a realigned SSI percentage and, in particular, does not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[2] Rather, it is simply that a different 12-month time period is used. Since the revised NPR for Washington Hospital did not adjust the Part C days issue or the SSI accuracy issue (which in part entails allegations of flaws and inaccuracies in CMS' matching process of patient records with SSA records) as required by 42 C.F.R. § 405.1889, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal the revised NPR for both issues and that, as a result, the Board lacks jurisdiction over both issues in the appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal

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

rights under 42 C.F.R. § 405.1889(b).[3] Accordingly, the Board hereby, dismisses both issues since it lacks jurisdiction over them ***and*** *denies the transfer* of the Accuracy of CMS Developed SSI Ratio issue from Case No. 20-1274 to Case No. 20-1587G.

Finally, the Board notes the Provider is not harmed by this dismissal since it already has previously appealed these issues from its original NPR for the same FYE and subsequently transferred the issues to group cases (Case Nos. 19-0040G and 19-2021G).

Conclusion

The Board concludes it does not have jurisdiction over the Accuracy of CMS Developed SSI Ratio and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issues appealed from the revised NPR issued for Washington Hospital for FYE 06/30/2015 because the issues were not specifically adjusted in the revised NPR. Accordingly, the Board dismisses these two issues from Case No. 20-1274 ***and*** *denies the transfer of the Accuracy of CMS Developed SSI Ratio issue from Case No. 20-1274 to Case No. 20-1587G.*

Since there are no other issues pending for the revised NPR appeal for Washington Hospital, Case No. 20-1274 is closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/2/2020

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Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Regional Health Rapid City Hospital (Prov. No. 43-0077)
Harrison Medical Center (Prov. No. 50-0039) *as a participants in*
Case No. 20-1675G

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced optional group appeal and found that it does not have jurisdiction over the Disproportionate Share Hospital ("DSH") Payment – SSI Fraction/Medicare Managed Part C Days issue in the above-reference optional group appeal. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The group appeal request was filed on May 14, 2020, appealing the DSH SSI fraction Part C Days issue, and stated the Contractor ". . . failed to include patient days applicable to MA [Medicare Advantage] patients who were eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction."[1]

There are ***only*** two Providers in this optional group appeal: Harrison Medical Center (Provider No. 50-0039, FYE 4/30/2007) and Regional Health Rapid City Hospital (Provider No. 43-0077, FYE 6/30/2007).

The Medicare Contractor issued a Notice of Reopening on April 4, 2019, for Harrison Medical Center. On April 5, 2019, the Medicare Contractor issued a Notice of Reopening for Regional Health Rapid City Hospital. The Notices of Reopening included identical language, confirming that the cost reports reopened to "adjust the SSI ratio based on the final SSI ratio provided from the Settlement Agreement and amend the Disproportionate Share Adjustment to account for the change in the SSI Ratio."[2]

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[1] Issue Statement at 1 (May 14, 2020).
[2] Cost Report Reopenings at 1 (Apr. 4, 2019 and Apr. 5, 2019)

On April 29, 2019, Harrison Memorial Hospital issued a revised NPR. On April 30, 2019, Regional Health Rapid City Hospital issued a revised NPR. The Providers were both transferred to this group appeal when the appeal was established.

Board's Decision:

The Board finds it does not have jurisdiction over the SSI Fraction Part C Days issue for either of the Providers' appeals from the revised NPRs. The MAC adjustments to the SSI ratio for the revised NPRs do not relate to the subject of this appeal because the question regarding the inclusion of Part C days in the SSI fraction were not a part of the cost report revision.

The regulation, 42 C.F.R. § 405.1889 (2019), describes the limited rights that providers have to appeal revised determinations:

> (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 42 C.F.R. §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (b)(2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considering in any appeal of the revised determination or decision.

42 C.F.R. § 405.1835(a)(1) provides:

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

These regulations make clear that a Provider can only appeal items that are "specifically adjusted" from a revised NPR. In this case, both Providers' Notices of Reopening stated:

> In accordance with the Integris Southwest Medical Center, et al., Settlement Agreement, we are hereby reopening the above-referenced cost report.

> The cost report is being reopened . . . [t]o adjust the SSI ratio based on the final SSI ratio provided from the Settlement Agreement and amend the Disproportionate Share Adjustment to account for the change in the SSI Ratio."

For Harrison Medical Center, the audit adjustment report described the adjustment to the SSI fraction (Adjustment No. 6) as "The latest SSI ratio percentage agrees with the SSI ratio percentage per the Integris settlement agreement." For Regional Health Rapid City Hospital, the Representative did not attach final audit adjustment report. Rather, for Regional Health Rapid City Hospital, the Representative only submitted an audit adjustment report that was still subject to supervisory review where additional adjustments could be made and this audit adjustment report did not show any adjustment to the SSI fraction.

For Harrison Medical Center, the SSI fraction was adjusted but only to implement the "Integris Southwest Medical Center, et al., Settlement Agreement." As such, Harrison Medical Center got what it agreed to per the Settlement agreement and has no basis upon which to be dissatisfied and appeal. In this regard, the Board notes that the whole purpose behind a settlement agreement is to resolve matters and bring finality and closure.[3] Moreover, there is no evidence that this agreed-to Settlement even otherwise adjusted or addressed the Part C days.

With respect to Regional Health Rapid City Hospital, there is no evidence that the SSI fraction was adjusted. Even if there were, it is clear that the reopening was simply to implement the "Integris Southwest Medical Center, et al., Settlement Agreement" and, as such, Regional Health Rapid City Hospital got what it agreed to per this Settlement agreement and has no basis upon which to be dissatisfied and appeal. In this regard, the Board notes again that the whole purpose behind a settlement agreement is to resolve matters and bring finality and closure and that there not even any evidence that this agreed-to Settlement even adjusted or addressed Part C days.

Conclusion

The Board concludes it does not have jurisdiction over either Provider pending in this appeal because both appealed from revised NPRs that simply implemented the "Integris Southwest Medical Center, et al., Settlement Agreement" and, as such, these two Providers have no basis upon which to be dissatisfied and appeal (indeed, there is no evidence that the Part C days issue itself was even adjusted under the agreed-to Settlement). Accordingly, the Board dismisses these two Providers from Case No. 20-1675G. As there are no remaining participants in the optional group under Case No. 20-1675G, the Board hereby closes it and removes it from the Board's docket.

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

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[3] To the extent the terms of the "Integris Southwest Medical Center, et al., Settlement Agreement" did not bring finality or closure to the matters covered by the Settlement Agreement, the Representative may present that evidence and request reconsideration by the Board.

Board Members Participating:

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

For the Board:

12/2/2020

X Clayton J. Nix

Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

cc: Wilson C. Leong, Esq., Federal Specialized Services
John Bloom, Noridian Healthcare Solutions

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

David Johnston
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215-4291

RE: ***Jurisdictional Decision***
Grady Memorial Hospital (Prov. No. 36-0210)
FYE 06/30/2010
Case No. 20-1836

Dear Mr. Johnston,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal. The Board finds that it does not have jurisdiction over the Improper Treatment of Part C Days in the DSH Calculation issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

In a reopening request filed with the Medicare Contractor on June 20, 2014, the Provider requested to ". . . recalculate the SSI percentages based on the Hospital's fiscal year rather than the federal fiscal year."[1] The Medicare Contractor's Notice of Reopening was issued on February 5, 2019, and confirmed that the cost report was reopened to adjust the SSI ratio based on the hospital's cost reporting period rather than the federal fiscal year.

On January 2, 2020, the Provider was issued a RNPR for fiscal year end June 30, 2010.

On June 30, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained one (1) issue:

1. Improper Treatment of Part C Days in the Disproportionate Share Hospital (DSH) Calculation

The Individual Appeal Request included a request from the Provider Representative to transfer the issue being appealed to a group appeal, PRRB Case No. 14-3067GC, OhioHealth Corporation 2010 Dual Elig CIRP Group.

[1] Grady Memorial Hospital Medicare Cost Report Reopening Request at 1 (June 20, 2014).

Board's Decision:

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

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

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

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

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

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

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

In this case, Grady Memorial Hospital appealed a revised NPR that did not adjust the Medicare Part C Days issue as required for Board jurisdiction, rather it was an appeal of a revised NPR issued to implement the Provider's request for an SSI realignment under 42 C.F.R. § 412.106(b)(3).

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

Grady Memorial Hospital requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. The Notice of Reopening clearly states that the purposes of the reopening was to "To update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 06/25/2014." To this end, the audit adjustment associated with the revised NPR under appeal clearly only revised the SSI percentage in order "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." To this end, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. When CMS performs the realignment process, it does not utilize a new or different data match process when it issues a realigned SSI percentage and, in particular, does not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[2] Rather, it is simply that a different 12-month time period is used. Since the revised NPR for Grady Memorial Hospital did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal

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

the revised NPR for the Part C days issue and that, as a result, the Board lacks jurisdiction over the sole issue in this appeal. Accordingly, the Board dismisses the Part C days issue and notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[3]

Additionally, the Board *denies the transfer request to PRRB Case No. 14-3067GC* for the same reason the Board dismissed the appeal issue, a lack of jurisdiction over an issue that was not adjusted in the revised NPR.

Finally, the Board notes the Provider is not harmed by this dismissal since it already has previously appealed these issues from its original NPR for the same FYE and subsequently transferred the issues to the group case under PRRB Case No. 14-3067GC.

Conclusion

The Board concludes it does not have jurisdiction over the Improper Treatment of Part C Days in the DSH Calculation issue appealed from the revised NPR issued for Grady Memorial Hospital for FYE 06/30/2010 because the issue was not specifically adjusted in the revised NPR. The Board also *denies the Provider's request to transfer the issue to PRRB Case No. 14-3067GC* for the same reason. Accordingly, the Board dismisses the issue from Case No. 20-1836.

Since there are no other issues pending for the revised NPR appeal for Grady Memorial Hospital, Case No. 20-1836 is closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/2/2020

X Clayton J. Nix

Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

David Johnston
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215-4291

RE: ***Jurisdictional Decision***
OhioHealth Mansfield Hospital (Prov. No. 36-0118)
FYE 06/30/2010
Case No. 20-1998

Dear Mr. Johnston,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced individual appeal. The Board finds that it does not have jurisdiction over the Improper Treatment of Part C Days in the DSH Calculation issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

In a reopening request filed with the Medicare Contractor on September 4, 2019, the Provider requested ". . . recalculate the SSI percentages based on the Hospital's fiscal year rather than the federal fiscal year."[1] The Medicare Contractor's Notice of Reopening was issued on September 6, 2019, and confirmed that the cost report was being reopened to adjust the SSI ratio based on the hospital's cost reporting period rather than the federal fiscal year.

On February 26, 2020, the Provider was issued a RNPR for fiscal year end June 30, 2010.

On August 24, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained one (1) issue:

1. Improper Treatment of Part C Days in the Disproportionate Share Hospital (DSH) Calculation

The Individual Appeal Request included a letter from the Provider Representative requesting to transfer the issue being appealed to a group appeal, PRRB Case No. 14-3067GC.

Board's Decision:

[1] OhioHealth Medicare Cost Report Reopening Request at 1 (Sep. 4, 2019).

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

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

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

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

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

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

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

In this case, OhioHealth Mansfield Hospital appealed a revised NPR that did not adjust the Medicare Part C Days issue as required for Board jurisdiction, rather it was an appeal of a revised NPR issued to implement the Provider's request for an SSI realignment under 42 C.F.R. § 412.106(b)(3).

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

OhioHealth Mansfield Hospital requested that its SSI percentage be recalculated from the federal fiscal year to its cost reporting year. The Notice of Reopening clearly states that the purposes of the reopening was to "To update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received September 4, 2019." To this end, the audit adjustment associated with the revised NPR under appeal clearly only revised the SSI percentage in order "To update the SSI% and payment factor in accordance with CMS' SSI realignment calculation." To this end, the audit adjustments associated with the revised NPR under appeal clearly only revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. When CMS performs the realignment process, it does not utilize a new or different data match process when it issues a realigned SSI percentage and, in particular, does not adjust any of the monthly data underlying the SSI percentages (*i.e.*, there is no change in or revision to Part C days or other aspects of the monthly data since the underlying monthly data remains the same).[2] Rather, it is simply that a different 12-month time period is used. Since the revised NPR for OhioHealth Mansfield Hospital did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that, pursuant to 42 C.F.R. §§ 405.1835(a)(1) and 405.1889(b), the Provider did not have the right to appeal the revised NPR for the Part C issue and that, as a result, the Board lacks jurisdiction over the sole issue in this appeal. The Board notes that Courts have upheld the Board's application of provider's limited appeal rights under 42 C.F.R. § 405.1889(b).[3]

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

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

Additionally, *the Board hereby denies the transfer request* to Case No. 14-3067GC for the same reason the Board dismissed the appeal issue, a lack of jurisdiction over an issue that was not adjusted in the revised NPR.

Conclusion

The Board concludes it does not have jurisdiction over the Improper Treatment of Part C Days in the DSH Calculation issue appealed from the revised NPR issued for OhioHealth Mansfield Hospital for FYE 06/30/2010 because the issue was not specifically adjusted in the revised NPR. *The Board denies the Provider's request to transfer* the issue to Case No. 14-3067GC for the same reason. Accordingly, the Board dismisses the issue from Case No. 20-1998.

Since there are no other issues pending for the revised NPR appeal for OhioHealth Mansfield Hospital, Case No. 20-1998 is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

12/2/2020

X Clayton J. Nix

Clayton J. Nix, Esq.

Signed by: Clayton J. Nix -A

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Lorraine Frewert,
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Fargo, ND 58108-6782

Re: ***Appeal Request Does Not Include Final Determination Document***
Highland Hospital (05-0320)
FYE 06/30/2017
PRRB Case No. 21-0156

Dear Mr. Goretti and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") is in receipt of the Provider's appeal request. The pertinent facts of the case and the Board's determination are set forth below.

Pertinent Facts:

Alameda Health System (the "Representative") filed an appeal on June 19, 2020, on behalf of the Provider. The Representative submitted a single letter indicating that the Provider was disputing ". . . certain aspects of the Notice of Amount of Program Reimbursement (NPR) issued by Noridian Healthcare Solutions on December 31, 2019." The letter listed the issue in dispute as Graduate Medical Education (GME) Payments – Full Time Equivalent (FTE) Counts – Current Year, Prior Year and Per Resident Amounts (PRAs), Audit Adjustment Nos. 1, 2, 38, 50, 75-77 and an estimated amount in controversy of $105, 307. A copy of Worksheet E-4 for FYE 06/30/2017 was included with the appeal request as support for the amount in controversy calculation. There was no other support included with the appeal request.

Decision of the Board:

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

Further, 42 C.F.R. § 405.1835(b) specifies that, if a Provider's appeal request does not meet the requirements of paragraph (b)(3) of the same section, the Board may dismiss the appeal with prejudice, or take any other remedial action it considers appropriate. Paragraph (b)(3) states in part that the following must be included in the Provider's request:

> A copy of the determination, including any other documentary evidence the provider considers necessary to satisfy the hearing request requirements . . . .

Attaching the actual determination being appealed to the appeal request is critical for a myriad of reasons, including to determine whether the Provider met the claim filing requirements specified in 42 C.F.R. § 405.1835. Because the Representative failed to submit the required copy of the final determination under appeal in the subject case, the Board finds that the Provider did not meet the regulatory requirements for filing an appeal before the Board. Accordingly, the Board finds dismissal is appropriate under § 405.1835(b) and Board Rules and hereby dismisses and closes Case No. 21-0156.

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 105.1877.

Board Members Participating:

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

For the Board:

12/2/2020

X Gregory H. Ziegler

Gregory H. Ziegler, CPA
Board Member
Signed by: Gregory H. Ziegler -S

cc: Wilson Leong, FSS

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Via Electronic Delivery

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

RE: ***EJR Determination***
McLaren Health CY 2015 DSH SSI Ratio Dual Eligible Days CIRP Group
Case No. 18-1692GC

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The Board's decision with respect EJR is set forth below.

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

By letter dated April 15, 2020, the Board sent the Group Representative notice for this CIRP group that the 30-day time period for issuing an EJR had been stayed consistent with Board Alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned CIRP appeal.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on October 7, 2019, the Board did not receive the EJR request for the above-referenced appeal in its office until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[4] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

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[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9]

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[5] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match

[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*

individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the

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[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.

forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

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[28] *Id.*
[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[41] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

<u>Providers' Request for EJR</u>:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

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[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] CMS published the SSI ratios for FY 2015 on or about July 6, 2017. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[44]

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. *Jurisdictional Determination*

The participants that comprise the CIRP group appeal within this EJR request have filed appeals involving calendar year 2015.

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

[42] 75 Fed. Reg. at 50275-86.
[43] *Id.* at 50281.
[44] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Bowen ("*Bethesda*").[45] 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.[46]

On August 21, 2008, new regulations governing the Board were effective.[47] 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*").[48] 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.[49]

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 finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in this CIRP case. Consequently, the Board finds that it has jurisdiction over the Providers in this CIRP case.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that

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[45] 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.).
[46] *Bethesda*, 108 S. Ct. at 1258-59.
[47] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[48] 201 F. Supp. 3d 131 (D.D.C. 2016).
[49] *Id.* at 142.

the estimated amount in controversy exceeds $50,000, as required for a group appeal.[50] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[51] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[52]

Contemporaneous with CMS Ruling 1498-R[53] the Secretary published a proposed IPPS rule[54] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[55]

Then she announced that:

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[50] *See* 42 C.F.R. § 405.1837.
[51] CMS Ruling 1498-R at 27.
[52] *Id.* at 31.
[53] *Id.* at 5.
[54] 75 Fed. Reg. 23852, 24002-07.
[55] 75 Fed. Reg. at 50277.

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[56]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[57]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[58] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

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[56] (Medicare) Enrollment Database.
[57] 75 Fed. Reg. at 50285.
[58] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

C. *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 participants in this CIRP group appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

12/11/2020

X Clayton J. Nix

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

Enclosures: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***EJR Determination***
Truman Med Ctr CY 2012 SSI Fraction Dual Eligible Days CIRP Group
Case No. 18-1853GC

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeal. The Board's decision with respect EJR is set forth below.

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

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

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on August 15, 2019, the Board did not receive the EJR request for the above-referenced appeal in its office until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[4] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

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[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9]

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[5] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match

[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*

individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the

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[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.

forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

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[28] *Id.*
[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[41] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[44]

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. Jurisdictional Determination

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

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

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[42] 75 Fed. Reg. at 50275-86.
[43] *Id.* at 50281.
[44] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Bowen ("*Bethesda*").[45] 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.[46]

On August 21, 2008, new regulations governing the Board were effective.[47] 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*").[48] 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.[49]

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 finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in this CIRP case. Consequently, the Board finds that it has jurisdiction over the Providers in this CIRP case.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that

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[45] 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.).
[46] *Bethesda*, 108 S. Ct. at 1258-59.
[47] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[48] 201 F. Supp. 3d 131 (D.D.C. 2016).
[49] *Id.* at 142.

the estimated amount in controversy exceeds $50,000, as required for a group appeal.[50] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. *Analysis Regarding the Appealed Issue*

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[51] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[52]

Contemporaneous with CMS Ruling 1498-R[53] the Secretary published a proposed IPPS rule[54] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[55]

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[50] *See* 42 C.F.R. § 405.1837.
[51] CMS Ruling 1498-R at 27.
[52] *Id.* at 31.
[53] *Id.* at 5.
[54] 75 Fed. Reg. 23852, 24002-07.
[55] 75 Fed. Reg. at 50277.

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[56]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[57]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[58] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

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[56] (Medicare) Enrollment Database.

[57] 75 Fed. Reg. at 50285.

[58] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

C. 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 participants in this CIRP group appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

12/11/2020

X Clayton J. Nix

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

Enclosures: Schedule of Providers for Case No. 18-1853GC (2 participants)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
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RE: ***EJR Determination***
Hall Render CY 2013 DSH SSI Fraction Dual Eligible Days IV Group
Case No. 18-1864G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced optional group appeal. The Board's decision with respect EJR is set forth below.

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

By letter dated April 15, 2020, the Board sent the Group Representative notice for this optional group that the 30-day time period for issuing an EJR had been stayed consistent with Board Alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned optional group appeal.

Although the hard copy Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on October 16, 2019, the Board did not receive the EJR request for the above-referenced appeal until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Issue in Dispute:

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

Medicare Disproportionate Share Hospital (DSH) Payment Background:

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[4] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9]

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[5] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[6] 42 U.S.C. § 1382.
[7] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[8] 20 C.F.R. § 416.202.
[9] 42 U.S.C. § 426.

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match

[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*

individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the

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[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.

forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

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[28] *Id.*
[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e*., for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 211 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation, and data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this optional group appeal.[41] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e*., use only the three SSI codes to denote SSI eligibility.

<u>Providers' Request for EJR</u>

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] The SSI ratios for FY 2009 and 2010 were published on March 16, 2012 and October 17, 2012, respectively. *See* https://www.cms.gov/Medicare/ Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[42]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[43] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[44]

Decision of the Board:

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

A. *Jurisdictional Determination*

The participants that comprise the group appeals within this EJR request have filed appeals involving calendar year 2013.

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

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[42] 75 Fed. Reg. at 50275-86.
[43] *Id.* at 50281.
[44] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).

Bowen ("*Bethesda*").[45] 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.[46]

On August 21, 2008, new regulations governing the Board were effective.[47] 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*").[48] 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.[49]

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 finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in this group case. Consequently, the Board finds that it has jurisdiction over the Providers in this group case.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that

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[45] 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.).
[46] *Bethesda*, 108 S. Ct. at 1258-59.
[47] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[48] 201 F. Supp. 3d 131 (D.D.C. 2016).
[49] *Id.* at 142.

the estimated amount in controversy exceeds $50,000, as required for a group appeal.[50] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Analysis Regarding the Appealed Issue

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[51] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[52]

Contemporaneous with CMS Ruling 1498-R[53] the Secretary published a proposed IPPS rule[54] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[55]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the

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[50] *See* 42 C.F.R. § 405.1837.
[51] CMS Ruling 1498-R at 27.
[52] *Id.* at 31.
[53] *Id.* at 5.
[54] 75 Fed. Reg. 23852, 24002-07.
[55] 75 Fed. Reg. at 50277.

> proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[56]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[57]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[58] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation the published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this case.

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[56] (Medicare) Enrollment Database.
[57] 75 Fed. Reg. at 50285.
[58] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

A. *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 participants in this group appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule 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 authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

12/11/2020

X Clayton J. Nix

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

Enclosures: Schedule of Providers

cc: Cecile Huggins, Palmetto GBA
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Denial – Lack of Jurisdiction for Part C Days Under CMS Ruling CMS-1739-R***
14-0821GC Cook County Chicago 2009 DSH Medicare/Medicaid Part C Days CIRP Group
15-1465GC Advocate Health Care 2012 DSH Medicare/Medicaid Fraction Part C Days CIRP
16-0044GC Cook County Chicago 2012 DSH Part C Days CIRP Group
16-2402GC Palmetto Health 2013 DSH Medicare/Medicaid Part C Days CIRP Group
17-0364GC Mayo Clinic Health Sys. Pre 10/1/2013 DSH Medicare/Medicaid Part C Days CIRP
17-0535GC Advocate Health Care Pre 10/1/2013 DSH Medicare/Medicaid Part C Days CIRP
19-1896G Hall Render CY 2011 DSH Part C Days Group V Group
19-2042G Hall Render CY 2014 (Pre 10/1/2013) DSH Part C Days Group

Dear Ms. Elias:

The above-referenced eight (8) group appeals include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review ("Board" or "PRRB") must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On October 8, 2020, requests for Expedited Judicial Review ("EJR") were filed in the above-referenced appeals for the Part C Days issue. On March 26, 2020, in response to the COVID-19 crisis, the Board issued Alert 19, which temporarily stayed the 30-day period for responding to EJR requests in a number of appeals. By letter dated October 19, 2020, the Board sent the Group representative notice that the 30-day time period for issuing an EJR had been stayed for these group appeals consistent with Board Alert 19. The Board's October 19, 2020 notice remains in effect.

Set forth below is the Board's decision to deny the requests for EJR based on CMS Ruling 1739-R.

Statutory and Regulatory Background

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[1] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[2]

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

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

[1] of Health and Human Services.
[2] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[3] *Id.*
[4] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-

Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.[5]

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

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

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[7] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[8]

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

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[5] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[6] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[7] 69 Fed. Reg. at 49099.
[8] *Id.* (emphasis added).

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

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

CMS Ruling 1739-R

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

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

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

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

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

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

> calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[17]

Providers' Request for EJR

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

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

Board's Decision and Analysis

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

Pursuant to CMS Ruling 1739-R, *as of August 17, 2020*, the Board no longer has jurisdiction over then-pending appeals of this issue and, to this end, the Ruling "requires that the PRRB remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[20] As CMS Ruling 1739-R confirms that the Board lacks jurisdiction over this issue, and as jurisdiction is a prerequisite for EJR, the Board denies the EJR requests. Pursuant to the Ruling, the Board must remand each "qualifying" appeal to the appropriate MAC. As such, the Board will be reviewing each of the group cases to determine if the Providers had "jurisdictionally proper" appeals prior to the Ruling (*i.e.*, determine if they are ripe for remand under 1739-R) and, as appropriate, remand pursuant to the Ruling. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeals.

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

Board Members Participating:

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For the Board:

12/18/2020

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

cc: Wilson Leong, FSS
Danene Hartley, National Government Services, Inc.
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran, President
Quality Reimbursement Services
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RE: ***EJR Determination***
17-1553GC Multicare 2014 SSI Fraction Dual Eligible Days Group
18-0678GC UW Medicine 2015 SSI Part A Days Group
18-1110GC Multicare 2015 SSI Fraction Dual Eligible Days Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group appeal.[1] On November 30, 2020, the Board asked the Group Representative to submit additional information related to the EJR request. The Group Representative responded on December 4, 2020. The Board's determination regarding EJR is set forth below.

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

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

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

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

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

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on March 3, 2020, the Board did not receive the EJR request for the above-referenced appeal in its office until March 13, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. Accordingly, the Board's April 9, 2020 notice remains in effect.

Issue in Dispute:

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

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

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

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

[2] (Emphasis added.)

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

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

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

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

Statutory and Regulatory Background: Medicare DSH Payment

Adjustment for Medicare DSH

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the

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

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

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[14]

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

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

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[15]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[16]

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

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

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

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for

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[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.* at 27207-27208.
[22] *Id.* at 27207-08.

Medicare contractors[23] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

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

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

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

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

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[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*
[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

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

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

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *Determines the number of* ***covered*** *patient days that—*

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

> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

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

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

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

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

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[36] (Emphasis added.)
[37] (Emphasis added.)
[38] *Id.*
[39] 317 F. Supp. 3d 168 (D.D.C. 2018).
[40] *Id.* at 172.
[41] *Id.* at 190.
[42] *Id.* at 194.
[43] *See* 2019 WL 668282.

decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

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

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

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[52] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[53] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[54] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[55] wherein the Ninth

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[44] 718 F.3d 914 (2013).
[45] 657 F.3d 1 (D.C. Cir. 2011).
[46] 718 F.3d at 920.
[47] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[48] *Id.* at 1141.
[49] *Id.*
[50] *Id. at 1162.*
[51] *Id. at 1163*
[52] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir., Oct. 20, 2020). It is unclear if the Secretary will petition the U.S. Supreme Court to review the Ninth Circuit's *Empire* decision.
[53] *Id.* at 884.
[54] *Id.* at 884.
[55] 97 F.3d 1261, 1265-66 (9th Cir. 1996).

Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[56] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[57] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[58] Accordingly, the Ninth Circuit to the following actions to implement its holding:

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

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

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

<u>Providers' Request for EJR</u>

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

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

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[56] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[57] *Id.* at 886.
[58] *Id.*
[59] Providers' EJR Request at 2.

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

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

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

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

The EJR request also puts forward challenges to the substantive validity of the revision to § 412.106(b)(2)(i) in Sections I.B.7. Here, the Providers argue that "[t]he plain and unambiguous language of the Medicare Act mandates exclusion of non-covered days from the Medicare fraction, and inclusion of those days in the Medicaid fraction." The Providers contend

[60] *Id.* at Section I.B.4.
[61] 746 F. 3d 1102 (D.C. Cir. 2014)
[62] Provider's EJR Request at Section I.B.5.
[63] *Id.* at 1107.
[64] Providers' EJR Request at Section I.B.6.

that the statutory scheme establishes that Medicare secondary payor days and exhausted benefit days are not "entitled to benefits under Part A."[65]

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

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

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 2014 and 2015.

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

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[65] *Id.* at 12 (citing to *Jewish Hosp. v. Secretary of Health & Human Servs.*, 19 F.3d 270 (6th Cir. 1994); *Legacy Emanuel Hosp. & Health Ctr. v. Shalala*, 97 F.3d 1261, 1264 (9th Cir. 1996).
[66] Providers' EJR request at 1.
[67] *Id.*
[68] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The

full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[69]

On August 21, 2008, new regulations governing the Board were effective.[70] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required, for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[71] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[72]

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

A. *Jurisdiction Limited to One Issue – the No-Pay Dual Eligible Days Issue*

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

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

Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[69] *Bethesda*, 108 S. Ct. at 1258-59.
[70] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[71] 201 F. Supp. 3d 131 (D.D.C. 2016).
[72] *Id.* at 142.

> *contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[73]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[74] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[75]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish this CIRP group clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction." Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be excluded from the Medicare fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[76] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[77]

B. Scope of No-Pay Dual Eligible Days Issue Limited to Medicare Fraction

Similar to 42 C.F.R. § 405.1835(b), 42 C.F.R. § 405.1837(c) (2014) specifies that request for a group appeal contain the following:

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

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

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

The Providers' issue statement filed to establish this CIRP group only appealed the Medicare fraction and does not dispute the Medicaid fraction.[78] As part of the group appeal request, 42 C.F.R. § 405.1837(c)(2) required the group appeal request to include a "precise description" of the one question of fact or law common to the group and to explain both "how and why" Medicare payment must be determined differently. In compliance with this regulation, the group

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

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

In this regard, the Providers' EJR request tried to analogize to Part C days to support its position that, if the no-pay days are excluded from the Medicare fraction, they must automatically be counted in both the numerator and denominator of the Medicaid fraction. However, the Board notes that, contrary to the Providers assertion, no-pay dual eligible days differ from Medicare Part C days. The Medicare Part C days issue deals with the days associated with a *class of patients*. Either ***all*** of the days *in toto* (*i.e.*, any day) associated with Medicare Part C beneficiaries are "entitled" to Medicare Part A or not. If they are not so entitled, then they are included in the Medicaid fraction by the clear terms of the DSH statute as the D.C. Circuit explained in *Allina*.[79]

In contrast, it is clear that the *class of patients* who are dual eligibles have Medicare Part A and that, as a *patient class*, days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction (*i.e.*, it is undisputed that some dual eligible patients have days paid under the Medicare Part A and were "entitled" to Part A benefits). Rather, the Providers are asserting that only in certain ***no-pay*** dual eligible situations (*e.g.*, exhausted benefits and MSP) must days associated with this class of patients be excluded from the SSI fraction. As a result, the Board disagrees with the Providers' assertion that exclusion of days associated with these no-pay dual eligible situations automatically means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*")[80] and CMS Ruling 1498-R2 wherein multiple possible treatments of no-pay dual eligible days are discussed. Indeed, the relief requested by the Providers appears to be consistent with the Administrator's 2000 decision in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[81]

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

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

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[79] 746 F.3d at 1108.
[80] 718 F.3d 914 (D.C. Cir. 2013).
[81] *See* 718 F.3d at 918, 92122 (discussing the *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years ealier in *Edgewater*").

previously in effect. Rather, the relief requested is seeking to address what *Empire* does not address, namely the regulation or rule previously in effect.[82]

C. Jurisdiction and EJR

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[83] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (2005) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years as noted above. The Providers

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

have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in this cases, the Board hereby closes the cases.

Board Members Participating:

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

FOR THE BOARD:

12/18/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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James Ravindran, President
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RE: ***Expedited Judicial Review Determination***
16-1992GC QRS MultiCare 2012-2013 Part A No Pay Group
17-2232GC QRS MultiCare 2014 Medicaid Fraction Dual Eligible Days CIRP Group
18-1113GC QRS MutliCare 2015 No Pay Part A Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the referenced-above common issue related party ("CIRP") group appeals.[1] On November 30, 2020, the Board requested additional information from the Group Representative in each of the three groups. The Group Representative's responses were received on December 4, 2020.[2] The Board's determination regarding EJR is set forth below.

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

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

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

[1] The EJR also included Case Nos. 14-3271GC, 13-2350GC, 13-2351GC, 14-2924GC, 15-0932GC, 15-1677GC, 18-0680GC, and 17-0955GC. The Board is responding to the request for EJR in those cases under separate cover.
[2] The sole Provider in Case No. 17-0844GC was consolidated into this group appeal; Case No. 17-0844GC was closed on December 10, 2020.

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

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on February 25, 2020, the Board did not receive the EJR request for the above-referenced appeals in its office until March 13, 2020, on the date that the Board and its staff were required to begin telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted on February 25, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner. Accordingly, the Board's April 9, 2020 notice remains in effect.

Issue in Dispute:

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

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

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

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

[3] (Emphasis added.)

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider contends that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. *The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.*
>
> *It is the Provider's contention that these days must be included in the Medicaid percentage*.[4]

The EJR request characterizes the issue in these appeals as:

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

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

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

Statutory and Regulatory Background

A. *Adjustment for Medicare DSH*

Part A of the Medicare Act covers “inpatient hospital services.” Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system (“IPPS”).[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

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

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage (“DPP”).[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12] The DPP is defined as the sum of two fractions expressed as percentages.[13] Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid” fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[14]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services (“CMS”), and the Medicare contractors use CMS’ calculation to compute a hospital’s DSH payment adjustment.[15]

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

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

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[16]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.[17]

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

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

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

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

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[23] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[24] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[25]

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

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

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

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

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

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[33]
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> ****
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> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[34]

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[35] In order to effectuate this policy change, the FY 2005

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

IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[36] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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

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

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

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

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[40] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is

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[36] *See id.* at 49099, 49246.
[37] (Emphasis added.)
[38] (Emphasis added.)
[39] *Id.*
[40] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[41] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[42] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[43] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[44] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[45] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[46] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[47]

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

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

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[53] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[54] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[55] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[56] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[57] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[58] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[59] Accordingly, the Ninth Circuit to the following actions to implement its holding:

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

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

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

Providers' Request for EJR

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

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

consistently: (1) they should be included in both the numerator and denominator of the SSI fraction; or (2) excluded from the numerator and denominator of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[60]

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

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

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

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

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

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

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

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

Finally, the EJR request contends "[a]lternatively . . . that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to included [*sic* include] unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare fraction."[67] In making this "alternative" contention, the EJR request notes that "[t]his contention is a separate and independent basis for granting EJR in this case" and that "the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."[68]

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

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

Decision of the Board

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

A. Jurisdiction over the Group Limited to One Issue – the Dual Eligible Days Issue

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

> ***Alternatively***, the provider contends [*sic* providers contend] that even if the challenged regulation were valid (which it is not), such that it would not be contrary to law to include non-covered days in the Medicare fraction, it is impermissibly inconsistent to include unpaid (i.e., non-covered days that are not paid by Medicare) in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction. *This contention is a separate* ***and*** *independent basis* for granting EJR in this case. As noted below, the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction.[69]

The Board notes that, pursuant to the regulation, 42 C.F.R. § 405.1837(a)(2), a provider has the right to a hearing as part of a group appeal for a cost reporting period, *only if* among other things, "[t]he matter at issue in the group appeal involves a *single* question of fact or interpretation of law, regulations or CMS Rulings with is common to each provider in the group."[70] To this end, 42 C.F.R. § 405.1837(f) provides "Limitations on group appeals" and specifies in Paragraph (1) that issues may not be added to any group appeals: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal . . . ."[71]

The Board finds that the statement above is a separate issue (as recognized by the Representative through the use of the words "separate and independent" contention) and that the statement above is a new issue that was ***improperly*** added to the appeal when the EJR request was filed. The group statement filed to establish each of these five CIRP groups clearly does not challenge how SSI entitlement is determined for purposes of the DSH adjustment calculation or contend that that "eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."

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[69] (Emphasis added.)
[70] (Emphasis added.)
[71] (Emphasis added.)

Rather, the group appeal challenges how *Medicare* entitlement is determined and asserts that unpaid dual eligible days should be included in the Medicaid fraction. Since the SSI entitlement days issue is a new issue and was not part of the original group issue statement, the Board is required to dismiss the issue from the group appeal pursuant to 42 C.F.R. § 405.1837(f)(1).[72] Consequently, the Board hereby dismisses the issue from the appeal and denies the EJR request relative to improperly added SSI entitlement days issue.[73]

B. Jurisdiction for Providers and EJR

The participants in this EJR request have filed appeals involving fiscal years 2012 through 2015.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[74] 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.[75]

On August 21, 2008, new regulations governing the Board were effective.[76] 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*").[77] 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.[78]

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[72] Moreover, the Board notes that, even if there was not the prohibition against adding issues to group appeals, the addition of this issue could not be considered timely since: (1) the add issue regulation at 42 C.F.R. § 405.1835(e) only applies to adding issues to individual appeal requests; and (2) the SSI days issue was not added to the group within the 180-day time period, as required by 42 C.F.R. § 405.1837(a)(1) (which incorporates § 405.1835(a) or § 405.1835(c)) and, thus, would not be timely.
[73] The Board further notes that the Provider failed to brief this improperly added issue as part of its EJR request.
[74] 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.).
[75] *Bethesda*, 108 S. Ct. at 1258-59.
[76] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[77] 201 F. Supp. 3d 131 (D.D.C. 2016).
[78] *Id.* at 142.

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

The Board has determined that the participants in the three groups involved with the instant EJR request are governed by CMS Ruling CMS-1727-R as the Providers are challenging the validity of a regulation as it relates to Dual Eligible Days. Finally, the appeals were timely filed and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[79] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying, remaining providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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

<u>Board's Decision Regarding the EJR Request</u>

The Board finds that:

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

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

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

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

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[79] *See* 42 C.F.R. § 405.1837.

> where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction."[80]

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

Board Members Participating:

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

FOR THE BOARD:

12/22/2020

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

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[80] *Id.* at 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***
Boulder Community Hospital (Prov. No. 06-0027)
FYE: 12/31/2009
Case No. 12-0520

Dear Mr. Nash and Mr. Leong:

The Provider has asked the Provider Reimbursement Review Board ("Board") to consider a good cause extension or equitable tolling to extend the time for filing the above referenced appeal. The decision of the Board is set forth below.

Pertinent Facts:

The Provider has asked the Board to consider a good cause extension or equitable tolling to extend the time for filing an appeal with the Board. The appeal was filed on August 15, 2012 regarding a Notice of Program Reimbursement ("NPR") dated January 21, 2011. The request for hearing was filed 572 days after the NPR was issued and was styled as a "Motion for Good Cause Extension or Request for Equitable Tolling."

The Provider contends that the Medicare outlier regulations – specifically, the regulations found at 42 C.F.R. §§ 412.80 through 412.86 and the Secretary's series of "annual regulations" resulting in establishing the fixed-loss thresholds ("FLTs") for the Provider's FYE under appeal – is contrary to the outlier payment statute and the intent of Congress, arbitrary and capricious, and otherwise contrary to law.[1] As a result, the Provider claims the FLTs used to calculate its outlier case payments were faulty and must be recalibrated and reset so that the Provider may file amended and additional claims for its outlier case payments.

[1] The Provider contends that Outlier Final Rule published at 68 Fed. Reg. 34494 (June 9, 2003) (codified at 42 C.F.R. pt. 412) contained "corrupt" data that has adversely affected cost determinations from FFYs 2004-2009. *See* Provider Hearing Request at 5.

The Provider asserts that two documents,[2] which form the evidentiary basis of the appeal were discovered more than 180 days after its final determination was issued. The Provider claims that these two documents demonstrate that the Secretary of DHHS knowingly and deliberately concealed information related to the calculation of the FLTs for FFYs 2003-2009. The documents were obtained through a FOIA request, and the Provider argues that the Secretary's published rulemaking intentionally omitted key information and data in his possession.[3]

Relevant Law and Request for Information:

A provider's right to a Board hearing is set forth in 42 C.F.R. § 405.1835(a) (2012):

> (a) *Criteria*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by an intermediary or Secretary determination, only if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for 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 (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s)).
>
> (2) The amount in controversy (as determined in accordance with §405.1839 of this subpart) is $10,000 or more; and
>
> (3) Unless the provider qualifies for a good cause extension under §405.1836 of this subpart, the date of receipt by the Board of the provider's hearing request is—

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[2] An HHS initial Executive Order 12666 Submission of an "Interim Final Rule" to the Office of Management and Budget, relating to its 2003 revisions to the Outlier Payment Regulations; and the HHS OIG Report, dated June 28, 2012, summarizing its review of the reconciliation process for outlier payments under the Medicare Part A prospective payment system.

[3] *See generally* Motion for Good Cause Extension of Time for Requesting a Board Hearing filed with the Individual Appeal Request (Aug. 15, 2012).

> (i) No later than 180 days after the date of receipt by the provider of the intermediary or Secretary determination; or
>
> (ii) If the intermediary determination is not issued (through no fault of the provider) within 12 months of the date of receipt by the intermediary of the provider's perfected cost report or amended cost report (as specified in §413.24(f) of this chapter), no later than 180 days after the expiration of the 12 month period for issuance of the intermediary determination. The date of receipt by the intermediary of the provider's perfected cost report or amended cost report is presumed to be the date the intermediary stamped ''Received'' unless it is shown by a preponderance of the evidence that the intermediary received the cost report on an earlier date.

Further, 42 C.F.R. § 405.1835(b) specifies what must be included in a request for a Board hearing and states, in pertinent part:

> The provider's request for a Board hearing must be submitted in writing to the Board, and *the request* ***must*** *include* the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraphs (b)(1), (b)(2), or (b)(3) of this section, *the Board may dismiss with prejudice the appeal*, or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the intermediary's or Secretary's determination under appeal.

Appeals to the Board must generally be filed within 180 days of the final determination and the request for hearing must demonstrate that it meets that requirement.[4] Notwithstanding, 42 C.F.R. § 405.1836 provides for an exception to the 180-day filing deadline:

> (a) A request for a Board hearing that the Board receives after the applicable 180-day time limit prescribed in §405.1835(a)(3) of this subpart must be dismissed by the Board, except that the Board may extend the time limit upon a good cause showing by the provider.
>
> (b) The Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be

[4] 42 C.F.R. § 405.1835(a)(3).

> expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time (as determined by the Board under the circumstances) after the expiration of the applicable 180-day limit specified in §405.1835(a)(3).
>
> (c) The Board may not grant a request for an extension under this section if—
>
> (1) The provider relies on a change in the law, regulations, CMS Rulings, or general CMS instructions (whether based on a court decision or otherwise) or a CMS administrative ruling or policy as the basis for the extension request; or
>
> (2) The date of receipt by the Board of the provider's extension request is later than 3 years after the date of the intermediary or other determination that the provider seeks to appeal.

Accordingly, if the Provider submits a written request for a good cause extension, the Board "may find good cause to extend the time limit ***only if*** *the provider demonstrates* in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as a natural or other catastrophe, fire, or strike)."[5] Further, the Provider must submit its request within a reasonable time,[6] but no later than three years after the date of the final determination.[7]

Here, the Provider properly submitted a motion for good cause extension with its appeal request. The Provider's motion argues that the Secretary's "intentional omission" of certain key facts and data, including "inflated" and "flawed" calculations which affect their outlier payments, constitutes such an extraordinary circumstance. Upon discovery of these omissions, the Provider filed the instant appeal and requests the Board find good cause for the delay, since the documents which revealed the Secretary's omissions were not public and not discovered until a FOIA request was resolved.

In its Ruling issued on November 17, 2020, the Board finding that equitable tolling is not applicable to Board proceedings and issued a Request for Information ("RFI") to evaluate whether good causes exists for the belated appeal. Specifically, the Board requested the Provider supplement the record with additional documentation or evidence that would indicate CMS purposely withheld information that would impact the Provider's reimbursement for the fiscal year at issue including, but not limited to, the relevant documents obtained through the Provider's FOIA request. The Board required the Provider to respond within thirty days of the

[5] 42 C.F.R. § 405.1836(b).
[6] *Id.*
[7] 42 C.F.R. § 405.1836(c).

RFI, which was December 17, 2020 and specifically exempted this deadline from the Board Alert 19 suspension of deadlines.[8] The Board further warned the Provider that the failure to respond by this deadline may result in dismissal. Notwithstanding, the Provider failed to submit a response by the December 17, 2020 deadline.

Failure to comply with the Board's deadline for submission of its response to the RFI can be found at 42 C.F.R. § 405.1868:

> (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.

Decision of the Board:

As noted in the Board's Request for Information, the instant appeal request was belatedly filed and the Motion for Good Cause contained therein to excuse the late filing did not fully support the request notwithstanding the filing requirements contained in 42 C.F.R. §§ 405.1835(b) and 405.1836(b). As the Provider's submission does not contain sufficient information to establish good cause under § 405.1836(b), the Board requested the Provider supplement the record with certain information no later than December 17, 2020. However, the Provider failed to respond by the December 17, 2020 deadline even though the Board warned the Provider that the filing deadline was exempt from the Alert 19 suspension of Board filing deadlines and that failure to respond by the December 17, 2020 deadline may result in dismissal. Pursuant to its authority under 42 C.F.R. § 405.1868(b) and to the mandate in 42 C.F.R. § 405.1836(a), the Board hereby dismisses the appeal and removes it from its docket.

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[8] *Available at* https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts.

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

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

FOR THE BOARD

12/30/2020

X Clayton J. Nix

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

cc: Justin Lattimore, Novitas Solutions, Inc.

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RE: ***Jurisdictional and EJR Decision on Remand***
Clarian West Medical Center (Prov. No. 15-0158)
FYE 12/31/2007
Case No. 12-0629

Dear Ms. Webster and Mr. Leong,

The Provider Reimbursement Review Board ("Board") has reviewed the record in this case as well as the U.S. District Court for the District of Columbia's and the Administrator's Orders for remand. The Board's decision on jurisdiction and expedited judicial review ("EJR") is set forth below.

Background:

This case involves an appeal filed on September 26, 2012 with the Board seeking to challenge disallowed outlier payments previously made to Clarian West Medical Center ("Provider") based on a recalculation of its cost-to-charge ratio. On December 6, 2013, the Board received Provider's Request for Expedited Judicial Review ("EJR") filed pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842. The Request for EJR posed the following six questions of law or regulations and requested the Board to decide whether the Board had the authority to decide them:

1. Whether the reconciliation process established under the outlier regulation 42 C.F.R. § 412.84(h), is invalid because it is inconsistent with the plain language and manifest intent of the Medicare PPS statute.

2. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is procedurally and substantively invalid because the regulation establishes no standards governing the exceptions process and related program instructions were not adopted in accordance with the notice and comment rulemaking requirements mandated by the Administrative Procedure Act and Medicare Act.

3. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is invalid because it violates the statutes and regulations governing claims payment determinations, including the four-year reopening period applicable to claims payment determinations, and statutory provisions expressly requiring CMS [*i.e.*, the Centers for

Medicare and Medicaid Services] to notify beneficiaries of final action taken on such claims.

4. Whether the reconciliation process established under the outlier regulation, 42 C.F.R. § 412.84(h), is invalid because the process, as applied, has a discriminatory application and effect on hospitals generally, and new hospitals in particular, and is, therefore, arbitrary and capricious.

5. Whether the reconciliation process applied under the outlier regulations, 42 C.F.R. § 412.84(h), is invalid because it violates the statutory prescription against the imposition of retroactive liabilities against providers and beneficiaries who are "without fault" with respect to overpayments on claims payment determinations rendered more than three years earlier.

6. Whether the assessment of interest against the Provider with respect to the retroactive recalculation of outlier payments for 2007 is invalid because it is contrary to controlling statutory provisions on interest and nearly 50 years of agency precedent construing those authorities.

The Board issued an EJR Decision on January 3, 2014 granting EJR over questions 1, 2, and 4 but dismissed questions 3, 5, and 6, finding that it lacked jurisdiction over those issues. As a result, the Board also denied EJR for questions 3, 5, and 6.

Subsequently, the Provider filed Civil Action No. 1:14-cv-00339-KBJ in the U.S. District Court for the District of Columbia. On November 30, 2020, the District Court ordered that the Provider's case be remanded to the Secretary of the U.S. Department of Health and Human Services with instructions to return the matter to the Board for further proceedings. Specifically, the District Court ordered the Board to reconsider its determination that it lacked jurisdiction over questions 3, 5, and 6 and the availability of EJR for those questions.

Pursuant to the District Court Order, on December 1, 2020, the Principal Deputy Administrator of the Centers for Medicare and Medicaid Services ("CMS") remanded this matter to the Board for further proceedings consistent with the Court's opinion. Accordingly, the Board reopened this case on December 11, 2020 and permitted the parties to file comments no later than December 18, 2020.

Position of the Parties:

The Provider filed comments with the Board on December 10, 2020, arguing that questions 3, 5, and 6 of its initial EJR request meet all of the statutory requirements for the Board to exercise jurisdiction pursuant to 42 U.S.C. § 1395oo(a)(1). Specifically, the Provider contends that:

1. Its request for a hearing was filed within 180 days of an appealable final determination (*e.g.,* the issuance of its Notice of Program Reimbursement ("NPR"));
2. It is undisputed that Provider is dissatisfied with the payment determination made via its NPR; and

3. The Medicare Contractor's recoupment in excess of $2 million satisfies the amount in controversy threshold.

The Provider further contends that the Board lacks the authority to grant the relief over the three questions at issue concerning:

1. The statutory and regulatory limitations on the reopening of claims payment determinations and the statutory requirements regarding notice to beneficiaries of claims redeterminations (question 3);
2. The statutory proscription against the imposition of retroactive liabilities after a period of years against providers that are "without fault" (question 5); and
3. The assessment of interest (question 6).

According, the Provider maintains that EJR is appropriate because the Board has jurisdiction over the questions but lacks the authority to grant the relief sought.

The Medicare Contractor did not file additional comments with the Board. However, the Board notes that the District Court's order for remand quotes the Secretary's position that she now "concedes that the Board [does have jurisdiction] with respect to claims 3, 5, and 6."[1]

<u>Decision of the Board:</u>

A Provider generally 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, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.[2] Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR.[3]

The Board has reviewed the record on remand. In this case, the Provider filed its appeal request on September 26, 2012 using the Model Form A – Individual Appeal Request. In this form, the Provider stated that it was appealing its FY 2007 NPR dated March 30, 2012 and, to that end attached, a copy of that final determination. The appeal request identified the following two issues stemming from Adjustment No. 9 on NPR "to adjust outlier amounts per CR7192[4] to amounts per calculation of the ***time value of money***"[5]:

1. Whether the Medicare Contractor's disallowance of outlier payments based on a recalculated cost-to-charge ratio was incorrect; and

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[1] Order Remanding Case to the Provider Reimbursement Review Board at 6, *Clarian Health West, LLC v. Azar*, No. 1:14-cv-00339-KBJ (D.C. Cir. 2020) (quoting Def.'s Mot. at 34).
[2] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[3] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[4] "CR7192" is Change Request 7192 for the Medicare Claims Processing Manual, CMS Pub. No. 100-04, Transmittal 2111 (Dec. 3, 2010) addressing outlier reconciliation and other outlier manual updates.
[5] (Emphasis added.)

2. Whether the Medicare Contractor's assessment of interest on this disallowance was both arbitrary and capricious and inconsistent with the statutory provisions governing outlier payments (*i.e.*, 42 U.S.C. § 1395ww(d)(5)(A)) and the statutory provisions governing the payment of interest (*i.e.*, 42 U.S.C. § 1395g(d).

The appeal was filed within 180 days of the NPR's issuance and the amount in controversy exceeds $10,000.

The Board finds that, in its January 3, 2014 EJR determination, it erred in dismissing questions 3, 5, and 6 based on a finding that it lacked jurisdiction over those issues. Specifically, the Board agrees with the Provider that it has met the jurisdictional requirements for a Board hearing on the merits of questions 3, 5, and 6 in the Provider's original EJR request because the determination from which the Provider appealed was the NPR and the Provider's dissatisfaction with outlier payments arises from Adjustment No. 9 on that NPR.

However, the Board's ruling that it has jurisdiction to hear the merits of these questions does not mean that the Board has the authority to review the underlying dispute and/or provide the relief being requested by the Provider. Questions 3 and 5 relate to benefits or coverage determinations[6] and the individual administrative claims appeal process to contest denials of benefits/coverage by the Medicare program. With regard to question 3, the Provider is essentially "challenging the outlier reconciliation process established under . . . 42 C.F.R. § 412.84(h)" by contending it otherwise improperly affected, revised or reopened the individual claim determinations of Medicare benefits that underlie the outlier payment disallowance (*i.e.*, the determination that a Medicare beneficiary was entitled to benefits for or coverage of a hospital stay). To the extent any claims were reopened, the Board would not have the authority to address those reopened claims because there is a separate administrative appeals process governing individual claims under Medicare Part A at 42 U.S.C. § 1395ff and 42 C.F.R. Part 405, Subparts G, H and I (2008).[7] Regardless, the Board lacks authority to address question 3 in the context of the Provider's challenge to the validity of 42 C.F.R. § 412.84(h) as the Board is bound to comply with Medicare regulations pursuant to 42 C.F.R. § 405.1867.

Similarly, with regard to Question 5, the Provider is essentially challenging "the outlier reconciliation process applied under . . . 42 C.F.R. § 412.84(h)" by contending it violates the statutory waiver provisions at 42 U.S.C. § 1395gg, which, in certain circumstances, waives liabilities against providers and beneficiaries who are "without fault" with respect to overpayments on claims payment determinations rendered more than three years earlier. The Board notes that this statutory waiver provision pertains only to an "overpayment *on behalf of individuals…*"[8] and not to aggregate payments

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[6] Coverage by the Medicare program of the hospital stays that underlie the outlier payments affected by the disputed outlier reconciliation process is not at issue here. Rather, the ***amount*** of payment for those otherwise covered hospital stays is.
[7] Moreover, the Board notes that, to the extent there were reopenings of any individual claim determinations *on Medicare benefits/coverage*, then the underlying Medicare beneficiaries themselves would necessarily be a party of interest and would need to be notified of the reopening, the revised determination, the hearing on appeal, *etc*.
[8] (Emphasis added.)

such as the *cost report* payments involved in this case.[9] The Administrator in *Athens-Limestone Hosp. v. BC/BS of Alabama*[10] included the following quote from a 1998 proposed rule to explain the statutory basis for CMS' policy of not applying the "without fault" provisions to aggregate overpayment issues:

> Under [42 U.S.C. § 1395gg], if the provider is found to be without fault for an overpayment, the individual who received the service for which payment was made is liable for the overpayment. Therefore application of the without fault provision in [42 U.S.C. § 1395gg] is limited to overpayments for individual claims for which liability can ultimately be shifted to a specific individual.
>
> Consequently, the without fault provisions under [§ 1395gg] do not extend to aggregate overpayment issues, such as Medicare cost report errors, because liability for an individual claim cannot be shifted to a specific individual. For certain providers, aggregate overpayments resulted from payment under a reasonable cost payment methodology in which payment is made on an interim basis throughout the year, with appropriate adjustments made upon settlement of the annual cost reports. Because Medicare cost report errors are not directly associated with specific services, liability cannot be shifted from a specific provider to a specific individual.
>
> Thus, the without fault provisions in this proposed rule would not apply to overpayments resulting from aggregate payment issues, such as cost report errors.[11]

Court have similarly upheld the limited application of § 1395gg.[12] Accordingly, to the extent the outlier reconciliation process implicates the "without fault" provision, it would have to be in the context of individual claim determinations. As noted above, there is a separate administrative appeals process for individual claim determinations. Thus, the Board lacks the authority to apply the without fault provisions as it lacks the authority to address individual claim determinations. Regardless, the Board lacks authority to address question 5 in the context of the Provider's challenge to the validity of 42 C.F.R. § 412.84(h) as the Board is bound to comply with Medicare regulations pursuant to 42 C.F.R. § 405.1867.

Finally, with regard to question 6, the Provider is essentially challenging the assessment of the "time value of money" specified at 42 C.F.R. § 412.84(m) by contending that this regulatory provision is

[9] *See* 68 Fed. Reg. 34494, 34500-34504 (June 9, 2003) (providing for a cost report reconciliation process for outlier payments beginning with discharges occurring on or after August 8, 2003).
[10] CMS Adm'r Dec. (Aug. 16, 1999), *modifying*, PRRB Dec. No. 1999-D51 (June 16, 1999).
[11] *Id.* at 4-5 (quoting 63 Fed. Reg. 14506, 14510 (Mar. 25, 1998)).
[12] *See, e.g., Maine Med. Ctr. v. Burwell*, 841 F.3d 10, 23-24 (1st Cir. 2016); *Visiting Nurses Ass'n of Southwestern Ind., Inc. v. Shalala*, 213 F.3d 352, 356-57 (7th Cir. 2000), *reh'g en banc denied* (Aug. 9, 2000); *MacKenzie Med. Supply, Inc. v. Leavitt*, 506 F.3d 341, 348-349 (4th Cir. 2007); *Las Mercedes Home Care Corp. v. Burwell*, 2014WL 12857877 at *10-11 (S.D. Fla. 2014).

contrary to controlling Medicare statutory provisions on interest. The Board has generally found that interest assessed on overpayments pursuant to 42 C.F.R. § 405.376 is outside of the cost report[13] and, thus, outside the Board's jurisdiction.[14] However, it is clear that the interest issue in dispute (*i.e.*, the "time value of money" issue) is incorporated into and part of the Provider's cost report as reflected in Audit Adjustment No. 9 and that, as a result, the Board has jurisdiction over the interest issue in dispute.[15] However, similar to questions 3 and 5, the Board lacks authority to address question 6 in the context of the Provider's challenge to the validity of 42 C.F.R. § 412.84(m) as the Board is bound to uphold Medicare regulations pursuant to 42 C.F.R. § 405.1867.

EJR is appropriate when the Board determines it has jurisdiction over an appealed issue, but lacks the authority to grant the relief sought.[16] As explained in the Board's January 3, 2014 EJR determination, the Board is without authority to decide the Provider's legal challenge to the validity of the regulation, 42 C.F.R. § 412.84(h) as posed in questions 1, 2, and 4. The Board hereby supplements that determination with the following findings:

1. The Board reverses its jurisdictional decision related to questions 3, 5, and 6 and confirms that it has jurisdiction over questions 3, 5, and 6; and

2. The Board incorporates questions 3 and 5 into the Provider's legal challenge of the validity of § 412.84(h) and the Board's granting of the Provider's request for EJR on that legal challenge because the Board is bound to comply with that regulation pursuant to 42 C.F.R. § 405.1867 and it is without authority to decide questions 3 and 5.

3. The Board grants EJR for question 6 challenging the validity of 42 C.F.R. § 412.84(m) because the Board is bound to comply with that regulation pursuant to 42 C.F.R. § 405.1867 and it is without authority to decide question 6.

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[13] The relevant part of the Board's enabling statute 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 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.

[14] *See, e.g., University of Pittsburgh Med. Ctr. v. Highmark Medicare Servs.* PRRB Dec. No. 2014-D26 (Sept. 23, 2014) (denying jurisdiction over interest issue involving application of 42 C.F.R. § 405.378). Further, the Board notes that its enabling statute at § 1395oo(f)(2) only addresses potential annual interest due to the Provider in the context of when a 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.
[15] The final rule adopting the outlier reconciliation process also makes it clear that providers could appeal disallowances resulting from that process to the Board, including the time value of money assessments imposed pursuant to 42 C.F.R. § 412.84(m). *See, e.g.,* 68 Fed. Reg. 34494, 34512 (June 9, 2003).
[16] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(a)(1).

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no remaining issues under dispute, the Board hereby closes the case.

BOARD MEMBERS:

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

FOR THE BOARD:

12/30/2020

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Corinna Goron
Healthcare Reimb. Servs., Inc.
17101 Preston Rd, Ste. 220
Dallas, TX 75248

RE: ***Rescission of Expedited Judicial Review***
University Medical Center New Orleans (Prov. No. 19-0005)
FYE 6/30/2009
Case No. 20-0016

Dear Ms. Goron:

By letter dated August 13, 2020, the Board reopened this case involving the University Medical Center New Orleans ("UMCNO") and its November 6, 2019 determination to grant expedited judicial review ("EJR") and issued a request for information ("RFI") to the UMCNO's representative, Healthcare Reimbursement Services, Inc. ("HRS"). The Board has reviewed the record and HRS' October 12, 2020 response to the Board's RFI. As set forth below, the Board hereby rescinds its EJR decision and dismisses UMCNO's appeal of the Part C Days issue.

Background:

On October 2, 2019, HRS established Case No. 20-0016 by filing an appeal request for UMCNO setting forth two issues – Part C Days in both the SSI and Medicaid Fractions of the Disproportionate Share Hospital ("DSH") payment. As part of this appeal request, HRS included the following certification:

> I certify to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. *See* 42 C.F.R. § 405.1835(b)(4)(i).

Eight days later, on October 10, 2019, HRS requested EJR of the two issues under appeal. On November 6, 2019, the Board granted EJR in the individual appeal and closed the appeal.

However, as noted in the Board's August 13, 2020 RFI, the following information subsequently came to the Board's attention:

1. HRS' letter of appointment as UMCNO's representative in this case for FY 2009 was on "LSU Health" letterhead and the appointment was made by "Louisiana State University (LSU) Health Care Services Division Hospitals."

2. For the *same* year at issue in this case (*i.e.*, 2009), there were other LSU Health CIRP Groups for the *same* Part C Days issue and that the Board closed these CIRP groups on August 21, 2019 and March 15, 2018, in response to requests for EJR that HRS filed as group representative in these CIRP groups. These CIRP groups are Case Nos. 14-1278GC and 14-1279GC and will be referred to as the "LSU 2009 Part C CIRP Groups."

3. In HRS' request for EJR in the LSU 2009 Part C CIRP Groups, HRS confirmed that the CIRP groups were "Complete," *i.e.,* fully formed, and thus, ripe for Board consideration of an EJR determination on the CIRP groups.[1] There were four (4) providers included on the Schedule of Providers for these CIRP groups, and three of these four providers (Provider Nos. 19-0183, 19-0122, and 19-0161) were also included on UMCNO's letter of representation for this case.

4. The docket for LSU Health CIRP groups *for a **prior** year* (*i.e.*, 2007) and the Schedule of Providers for the appeal requests filed in the 2007 LSU Health CIRP groups under Case Nos. 13-3489GC and 13-3490GC are still open and both include UMCNO.[2]

After the above information came to the Board's attention, the Board issued an RFI requesting the following:

1. Notify the Board if UMCNO was part of the LSU Health chain during its FY 2009 that was the subject chain of Case Nos. 14-1278GC and 14-1279GC for the Part C Days issue for FY 2009.

2. If not but UMCNO was part of a chain *other than* the subject chain of Case Nos. 14-1278GC and 14-1279GC during FY 2009, identify the name of the provider chain and list the hospitals that were part of that chain.

3. If yes (*i.e*., UMCNO was part of the subject chain of Case Nos. 14-1278GC and 14-1279GC for FY 2009), show cause as why the Board should not rescind the November 6, 2019 EJR determination for UMCNO in Case No. 20-0016 and dismiss Case No. 20-0016 due to this Provider's failure to join Case Nos. 14-1278GC and 14-1279GC prior to the Board granting EJR in Case Nos. 14-1278GC and 14-1279GC

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[1] *See* footnote 1 of the EJR request for Case Nos. 14-1278GC and 14-1279GC.
[2] The Schedule of Providers in these cases listed Interim LSU Public Hospital, Prov. No. 19-0005, FYE 6/30/2007 of New Orleans, LA. While the name of the hospital is different, the provider number listed for "Interim LSU Public Hospital" is 19-0005 which is the same provider number listed in this case for UMCNO and has the same location. Accordingly, the Board concludes that for FY 2007, UMCNO was doing business under a different name.

and closing them. The Board noted its decisions to grant EJR in Case Nos. 14-1278GC and 14-1279GC was based in part on to HRS certifying that Case Nos. 14-1278GC and 14-1279GC were "Complete," *i.e.,* fully formed when it filed its request for EJR in Case Nos. 14-1278GC and 14-1279GC.

The Provider responded with the following:

1. HRS indicated that UMCNO was part of the LSU Health Chain during FY 2009.

2. N/A – the Provider was not part of another chain for FY 2009.

3. HRS argues that the Board should not rescind its November 6, 2019 EJR determination because UMCNO's certification was correct in accordance with the regulations, and because the Board does not have jurisdiction over this case because it is in court.

   On October 2, 2019, the Provider's representative certified that, "to the best of my knowledge that there are no other providers to which this provider is related by common ownership or control that have a pending request for a Board hearing on any of the same issues for a cost reporting period that ends in the same year covered in this request. See 42 C.F.R. § 405.1835(b)(4)(i)."

   HRS argues that this certification was accurate because at that time there was no other related provider that had pending a request for a Board hearing on the same issue or issues for the same cost year, the Board having previously granted EJR on March 15, 2018 for the Medicaid fraction Part C group (14-1279GC) and on August 21, 2019 for the SSI fraction Part C days group (14-1278GC). HRS also argues that when these two group appeals were filed, University Medical Center New Orleans did not have a pending request for a Board hearing.

   Last, HRS argues that because this case is pending in court, the Board has been divested of jurisdiction and does not have the authority to reopen and revise the final decision unless the case is remanded to the Board by the court.

<u>Rules on Mandatory Common Issue Related Party (CIRP) Groups</u>

By way of background, chain provider organizations are subject to the following requirement in 42 U.S.C. § 1395oo(f)(1):

> Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) ***must*** *be brought* by such

> providers *as a group* with respect to any matter involving an issue common to such providers.[3]

This statutory provision was implemented at 42 C.F.R. § 405.1837(b)(1)(i) and this regulation mandates the use of a CIRP group appeal where:

> *Two or more providers under common ownership or control* that wish to appeal to the Board a specific matter at issue that involved a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, *must bring the appeal as a group appeal*.

Further, 42 C.F.R. § 405.1835(b) address the "Contents of request for a Board hearing" and requires the following in paragraph (4) *when a provider is under common ownership or control*:

> (b) *Contents of request for a Board hearing on final contractor determination.* The provider's request for a Board hearing under paragraph (1) of this section **must be submitted in writing** to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4)** of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, **the Board may dismiss** with prejudice the appeal or take any other remedial action it considers appropriate.
>
> * * * *
>
> (4) **With respect to a provider under common ownership or control**, the name and address of its parent corporation, and a statement that –
>
> (i) To the best of the provider's knowledge, no other provider to which it is related by common ownership or control, has pending a request for a Board hearing pursuant to this section or pursuant to § 405.1837(b)(1) on any of the same issues contained in the provider's hearing request for a cost reporting period that ends within the same calendar year as the calendar year covered by the provider's hearing request; or

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[3] (Emphasis added).

> (ii) Such a pending appeal(s) exists(s), and the provider name(s), provider number(s), and the case number(s) (if assigned), for such appeal(s).

42 C.F.R. § 405.1837(e)(1) and Board Rules further address the mandatory use of CIRP groups. First, 42 C.F.R. § 405.1837(e)(1) addresses full formation of groups:

> When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, *no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal*.[4]

Further, the current Board Rules issued on August 29, 2018 states:

> **12.3 Types of Groups**
>
> **12.3.1 Mandatory Common Issue Related Part ("CIRP") Group**
>
> Providers under common ownership or control that with to appeal a specific matter that is common to the providers <u>must</u> bring the appeals a group appeal. *See* 42 C.F.R. § 405.1837(b).
>
> ****
>
> **Rule 19 – Full Formation of Groups**
>
> Reference 42 C.F.R. § 405.1837(e) regarding group appeal procedures pending full formation of the group and issuance of a Board decision.
>
> **19.2 – Mandatory (CIRP) Groups**
>
> Mandatory CIRP group appeals <u>must contain all Providers eligible to join the group</u> which intend to appeal the disputed common issue. <u>The Board will determine that a CIRP group appeal is fully formed upon</u>:

[4] (Emphasis added.)

> • Written notice from the Group Representative that the group is fully formed, or
>
> • A Board order issued after the Group Representative has the opportunity to present evidence regarding whether any CIRP providers who have not received final determinations could potentially join the group. . . .[5]

Because the issue that was under appeal is a challenge to the validity of a regulation, it lends itself to the group appeal format and, as a result, the Board has consistently determined the Part C Days issue is a "common issue" that chain providers are required to pursue in CIRPs to the extent the other elements of 42 C.F.R. 405.1837(b)(1) are met.

Issue in Dispute:

The issue in this appeal in this case was:

> Whether HMO/Medicare Plus Choice/Medicare Managed Care/Medicare Part C/Medicare Advantage ("MA") Days were properly accounted for in the Disproportionate Share Hospital ("DSH") calculation.[6]

This issue will be referred to as the Part C Days issue in the discussion below. The Part C Days issue challenges the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule) as promulgated in August 11, 2004 Federal Register.[7]

Importantly, the Board notes that there were LSU Health CIRP Groups for the Part C Days issue, which were closed on August 21, 2019 and March 15, 2018, in response to the Providers' requests for EJR:

14-1278GC HRS LSU 2009 DSH SSI Fraction Medicare Managed Care Part C Days

14-1279GC HRS LSU 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days

In its response to the Board's Request for Information ("RFI"), the Provider's representative confirmed that UMCNO was part of the LSU Health Chain during FY 2009, the year at issue in this case. Therefore, pursuant to the regulations and Board Rules discussed above, UMCNO was required to be a participant in the groups with the other CIRP providers appealing the Part C days issue for 2009, which have since been closed.

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[5] (Underline emphasis added).
[6] Provider's Individual Appeal Request Issue Statements for Issues 1 and 2.
[7] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

The Board finds that HRS' certification was ***not*** accurate and, based on HRS' representation of LSU Health in the LSU 2009 Part C CIRP Groups (as well as the similar LSU Health CIRP groups for 2007 as noted above), it is clear that HRS should have known that its certification was not accurate. Although there were no LSU Health CIRP providers with pending appeals before the Board at the time UMCNO filed its appeal, this is because the other LSU Health providers had already been in CIRP groups for which HRS was the representative and in which the Board granted EJR. In this regard, the certification requirement cannot be read in isolation as 42 C.F.R. § 405.1837(b) and Board Rule 19.2 also create separate and independent obligations on both LSU Health and UMCNO (as well as HRS as representative for LSU Health and UMCNO). To the extent UMCNO wished to pursue the Part C Days issue, HRS should have kept these LSU 2009 Part C CIRP Groups open until UMNCO received its final determination and could join the CIRP groups.[8] Instead, HRS certified these CIRP groups complete and, accordingly, per Board Rule 19.2, the Board deemed these CIRP groups complete.

The Board finds that: (1) 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required UMCNO to be in the CIRP groups referenced above as UMCNO was part of LSU Health in 2009 and is still part of LSU Health; and (2) as those 2009 CIRP groups have since fully formed and closed, UMCNO forfeited its right to appeal the Part C Days issue for 2009. The Board's decision is consistent with the mandate in 42 C.F.R. § 405.1837(e)(1) that "[w]hen the Board has determined that a [CIRP] group appeal . . . is fully formed, absent an order from the Board modifying its determination, *no other provider* under common ownership or control *may appeal to the Board the issue that is the subject of the group appeal* with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal."[9] The fact that UMCNO is currently in court based on the Board's prior EJR decision does not prevent the Board from reopening that decision pursuant to 42 C.F.R. § 405.1885 when new information bearing on that decision comes to its attention. To do otherwise here would reward HRS for its mismanagement of the UMCNO and LSU Health appeals for the year 2009. Accordingly, based on the above findings, the Board hereby rescinds the November 6, 2019 EJR decision and dismisses the Part C Days issue from the appeal because 42 C.F.R. § 405.1837(b)(1)(i) and Board Rule 19.2 required UMCNO to be in the LSU Part C CIRP groups and 42 C.F.R. § 405.1837(e)(1) precludes UMCNO from pursuing this issue. As there are no remaining issues, the Board once again closes Case No. 20-0016.

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[8] In this regard, the Board takes administrative notice that, in LSU Health provider appeals ***for 2011***, HRS ***did*** notify the Board it was keeping the LSU CIRP groups for Part C Days for 2011 (Case Nos. 14-2995GC and 14-2994GC) open until UMCNO could join. Notwithstanding, after filing an appeal for UMCNO on October 17, 2019 for FY 2011, HRS requested EJR on November 5, 2020 for UMNCO from the individual appeal. In this case, the Board discovered HRS' error ***prior to*** the full formation and closure of the FY 2011 CIRP groups. On January 10, 2020, the Board ultimately denied EJR in the individual case and required HRS to transfer the issue to the CIRP groups within 10 days or be subject to dismissal consistent with Board rules and regulations governing CIRP groups. The Board further *reprimanded* HRS for its mismanagement of the LSU Health cases for 2011. On January 17, 2020, HRS transferred the Part C Days issue to the FY 2011 CIRP Groups and then, on March 4, 2020, requested EJR for the FY 2011 CIRP groups. On March 31, 2020, the Board granted EJR for the FY 2011 CIRP groups.
[9] (Emphasis added.)

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

Board Members Participating:

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

For the Board:

12/30/2020

X Clayton J. Nix

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

cc: Justine Lattimore, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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Danene Hartley
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MP: INA 101-AF42
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RE: ***Jurisdictional Decision in Part***
St. Joseph Hospital of Orange (Provider No.: 05-0069, FYE: 2009)
as a participant in
Case Nos. 14-3331G, 14-3335G

Dear Mr. Putnam and Ms. Hartley,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeals as part of its review of jurisdiction for remands guided by CMS Ruling 1739-R for Part C Days issues. The group appeals contain Providers that appealed from Revised NPRs. The Board's decision is set forth below.

Background:

PRRB Case No. 14-3331G – SRI 2009 Medicare Fraction Part C Days Group

PRRB Case No. 14-3335G – SRI 2009 Medicaid Fraction Part C Days Group

The Board received the Providers Requests for Hearing dated April 23 and April 24, 2014, respectively, which include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

This issue is governed by Ruling CMS-1739-R and, under the terms of this Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule.

In its review of the jurisdictional documentation for the remand in the above cases, Provider St. Joseph Hospital of Orange (Prov. No. 05-0069), in its original appeal[1] was noted to have appealed

[1] Before the relevant Part C issue was transferred to its specific group appeal.

from a Revised Notice of Program Reimbursement ("RNPR") where the SSI percentage was not adjusted. The Provider's RNPR, dated March 26, 2013, was accompanied by the Notice of Reopening, date March 4, 2013. The Notice of Reopening was to:

- To correct the biweekly payments;
- To correct the retroactive lump sum payments.[2]

There is no indication of any specific adjustment to either the SSI or Medicaid fraction in the reopening.

<u>Board's Analysis and Decision</u>

The Code of Federal Regulations provides for an opportunity for issuance of a revised determination (*e.g*., an RNPR). Specifically, 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

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

[2] Provider's Notice of Reopening (Mar. 4, 2013).

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

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

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

- To correct the biweekly payments;
- To correct the retroactive lump sum payments.[3]

The RNPR regulations make clear that a Provider can only appeal items that are *specifically* adjusted from a revised NPR. Accordingly, the Board finds that it does not have jurisdiction over the Provider's appeal from the RNPR, as neither the SSI/Medicare nor the Medicaid fraction was *specifically* adjusted for the Part C days issue in the Provider's RNPR. Indeed, no component of the DSH adjustment calculation was adjusted As Part C Days was not part of the reopening appealed and there were no adjustments to Part C days in the SSI or Medicaid fractions, the Board lacks jurisdiction from the RNPR for those DSH percentage component related issues because the Provider had no appeal rights under 42 C.F.R. §§ 405.1835(a)(1) and 405.1889. As such, the Board hereby dismisses the RNPR appeal of St. Joseph Hospital of Orange from both group cases. The Board will address the applicability of CMS Ruling 1739-R under separate cover.

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

<u>Board Members Participating</u>:

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

For the Board:

12/30/2020

X Clayton J. Nix

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

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

[3] Provider's Notice of Reopening (Mar. 4, 2013).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Denial for Case No. 14-3271GC***
14-3271GC QRS Providence 2006 Medicaid Fraction Dual Eligible Days Group

Dear Mr. Nord:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 13, 2020 request for expedited judicial review ("EJR") for Case No. 14-3271GC. On November 30, 2020, the Board issued a Request for Information ("RFI") with respect to both Providers in the appeal. Based on the Group Representative's October 29, 2020 letter inquiring about the status of this EJR request, the Board specifically exempted the December 30, 2020 filing deadline from Board Alert 19 suspension of deadlines and warned the Group Representative that "failure of the Group Representative to file a response to the Board's deadline will result in the Board taking action without the benefit of the Group Representative filing and may result in the Board taking remedial action such as denial of the EJR request and/or dismissal of this case." As of the date of this letter, the Group Representative has not responded to the Board's RFI.

As set forth more fully below, the Board is denying the EJR request because the Board was not able to establish jurisdiction for either Provider in the appeal and because the Group Representative failed to respond to the Board's RFI.

Issue in Dispute:

The issue in this appeal is:

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

> Medicare fraction of the DSH adjustment, and instead included in the Medicare 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 inpatient prospective payment system ("IPPS").[2] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[3]

The statutory provisions governing IPPS contain 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 IPPS 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]

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[1] Providers' EJR request at 2-3.
[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.)

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]

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]

Dual Eligible Days

In the preamble to FY 2004 IPPS proposed rule published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[13] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are excluded from the Medicaid fraction.[14]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage is exhausted."[15] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's

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[10] 42 C.F.R. § 412.106(b)(2)-(3).
[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(4).
[13] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[14] *Id.*
[15] *Id.*

Medicaid coverage is exhausted.[16] The Secretary then summarized its policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[17]

The Secretary stated that he believed that the current policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[18] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractor`s[19] to differentiate the days for dual eligible patients who Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on the manner in which States identify dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or required the MACs or hospitals undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States in which the beneficiaries exhausted the Medicare Part A coverage and no Part A bill may be submitted for the patients. Consequently, the relevant MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[20]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and begin to count the patient days of dual-eligible Medicare beneficiaries whose Medicare coverage was expired in the Medicaid fraction of the DSH patient percentage.[21] Specifically, the Secretary proposed that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[22] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [23] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits have been exhausted.[24]

When the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[25] Rather, he

[16] *Id.*
[17] *Id.* at 27207-27208.
[18] *Id.* at 27207-08.
[19] MACs were formerly known as fiscal intermediaries or intermediaries.
[20] 68 Fed. Reg. at 27208.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).

stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[26]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[27]

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

> It has come to our attention that we inadvertently misstated our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[28]
>
> ****
>
> . . . [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[29]

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[26] *Id.*
[27] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[28] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[29] *Id.* at 49099 (emphasis added).

Accordingly, the Secretary adopted a new policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[30] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[31] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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

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

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

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[32]

The Board notes that two courts have reviewed and upheld the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[33] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is

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[30] *Id.*
[31] *See id.* at 49099, 49246.
[32] *Id.*
[33] 317 F. Supp. 3d 168 (D.D.C. 2018).

procedurally defective and arbitrary and capricious.[34] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is not procedurally defective.[35] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[36] The *Stringfellow* decision was appealed to the D.C. Circuit Court of Appeals; however, it was later dismissed.[37]

In the second case, *Empire Health Found. v. Price* ("*Empire*"),[38] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[39] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[40] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate contest in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[41] and that the regulation is procedurally invalid.[42] The *Empire* decision is currently pending on appeal in the Ninth Circuit Court of Appeals.[43]

As of the date of this decision, the Secretary's position with respect to the validity of the regulation has not changed.

<u>Providers' Request for EJR</u>

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

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[34] *Id.* at 172.
[35] *Id.* at 190.
[36] *Id.* at 194.
[37] *See* 2019 WL 668282.
[38] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[39] *Id.* at 1141.
[40] *Id.*
[41] *Id. at 1162.*
[42] *Id. at 1163*
[43] PACER: https://ecf.ca9.uscourts.gov/n/beam/servlet/TransportRoom. (last visited 02/05/2020).

and bottom of the SSI fraction and then be recognized in the numerator of the Medicaid fraction.[44]

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

The Providers assert that the Secretary improperly promulgated the revision to § 412.106(b)(2)(i) as part of the FY 2005 IPP final rule and that this revision should be vacated. In support of its position, the Providers note that, in *Allina Health Servs. v. Sebelius* ("*Allina*"), the D.C. Circuit recently invalidated a different regulatory revision made in the same rulemaking.[45] In *Allina*, the D.C. Circuit vacated the Secretary's regulation requiring Part C days be included in the Medicare fraction where the Secretary's policy prior to October 1, 2004 was to exclude Part C days from the Medicare fraction. The Court concluded that the Part C days regulation was not a logical outgrowth of the proposed regulation and that the proposed rule was merely an indication that the Secretary was considering a clarification of existing policy rather a reversal of the existing policy.

The Providers argue that the dual eligible days proposed rule as published in the FY 2004 IPPS proposed rule was equally misleading with respect to the Secretary's policy. As with the Secretary's Part C days policy, the Secretary adopted a policy with regard to dual eligible days that was the reverse of the proposed regulation and erroneously described the policy with respected to dual eligible days in the FY 2004 IPPS proposed rule. The Provider's contend that the convoluted nature of this rulemaking in which the Secretary both got her facts mixed up while at the same time shifting positions could only create among the public the type of hopeless confusion which the D.C. Circuit found in *Allina.*[46]

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

The Providers point out that there are no factual matters to be resolved with respect to the issue in these cases and the Board has jurisdiction over the appeals. The Providers maintain that EJR is appropriate since the Board is without the authority to grant the relief sought, namely a finding that as a matter of law 42 C.F.R. § 412.106(b)(2)(i), as revised by the FY 2005 IPPS final rule

[44] Providers' EJR Request at 2.
[45] 746 F. 3d 1102 (D.C. Cir. 2014)
[46] *Id.* at 1107.

for the purpose of mandating the inclusion of non-covered days in the Medicare fraction, is not valid.

Board's Decision and Analysis

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

It appears that the following two Providers in this group appeal were directly added to a CIRP group under Case No. 09-1746GC and then transferred to this CIRP group, 14-3271GC:

#1 Providence General Medical Center (Provider No. 50-0015, FYE 12/31/2006); and
#2 Providence St. Peter Hospital (Provider No. 50-0024, FYE 12/31/2006)

However, when the Schedule of Providers and accompanying jurisdictional documents were filed, the Group Representative did not include the original hearing request (including a statement of the issue) submitted in Case No. 09-1746GC under Tab G in Case No. 14-3271GC. This document which includes a statement of the issue appealed in Case No. 09-1746GC and is part of establishing the full history of the case is required by Board Rules[47] 21.3.1 and 21.8.2. These Rules state that, with the Schedule of Providers, providers are to:

> 21.3.1 Column B
>
> Enter the date on which the original hearing request was filed with the Board (see Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request (see Rule 6.2.1), also enter the date that the request to add the issue was filed.
> • If the appeal request was filed prior to August 21, 2008, the date of filing is the postmark date. See 42 C.F.R § 405.1801(a)(2007).
> • If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the PRRB. See 42 C.F.R. § 405.1801(a)(2008).
>
> 21.3.2 Documentation – Tab B

[47] The Board's Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.

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

Board Rule 21.8.1 states that "if the cases were restructured, include a copy of the *request to restructure*[48] and the Board's letter restructuring the case. The letters should be placed under the tab in chronological order Provider Reimbursement (earliest to latest) to correspond with the schedule of providers." Further, Board Rule 21.8.2 states that "[t]he letter or Model Form transferring the issue from the individual appeal to a group appeal, as well as any subsequent transfer to a second or third group must be placed under this tab. If the cases were restructured, include a copy of the request to restructure and the Board's letter restructuring the case. The letters should be placed under the tab in chronological order."

Notwithstanding the Group Representative's failure to include the required information with the Schedule of Providers, the Board issued a RFI on November 30, 2020 regarding #1 Providence General Medical Center and #2 Providence St. Peter Hospital. However, QRS failed to timely respond and still has not submitted the CIRP group appeal request that established Case No. 09-1746GC with the Schedule of Providers submitted in this case, Case No. 14-3271GC in order to confirm the exact issue in Case No. 09-1746GC that the provider appeal. To this end, the Board requested that the Group Representative update the Schedule of Providers with the full appeal history for each Provider including a copy of the group appeal request for Case No. 09-1746GC.

Failure to comply with the Board's deadline for submission of its response to the RFI can be found at 42 C.F.R. § 405.1868:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulation, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and the regulations in tis 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 –

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[48] (emphasis added).

(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.

QRS failed to submit the required information with its original filing of the Schedule of Provider and further failed to timely submit the missing information in response to the Board's RFI. Without it, the Board is not able to determine whether the Providers filed jurisdictionally valid appeals. Specifically, without the group issue statement from Case No. 09-1746GC, the Board is unable to determine what issue the providers appealed through their direct add to Case No. 09-1746GC prior to their transfer to the current group. Therefore, the Board finds that it does not have jurisdiction over the two Providers in this group appeal. In summary, the Board dismisses #1 Providence General Medical Center and #2 Providence St. Peter Hospital from Case No. 14-3271GC pursuant to its authority under 42 C.F.R. § 405.1868(b) based on QRS' failure to timely respond to the Board's RFI and, alternatively, based on the lack of jurisdiction. As jurisdiction is a requisite for EJR, the Board denies the Providers' EJR request. The Board hereby closes Case No. 14-3271GC and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

12/31/2020

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: **Jurisdictional Decision in Whole**
Riverside Methodist Hospital (Prov. No. 36-0006
FYE 6/30/2010
Case No. 14-3960

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to a jurisdictional challenge filed by the Medicare Administrative Contractor ("Medicare Contractor") regarding Riverside Methodist Hospital's ("Provider") issues in its individual appeal from its Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Provider Reimbursement Review Board (the "Board") received the Provider's Request for Hearing dated August 18, 2014, related to a NPR dated February 19, 2014.[1] The Provider's Request for Hearing included three issues:

1. Adjustment# 19, 21, 22 and 45* - Protested amounts - The DSH - SSI percentage was calculated using the Federal Fiscal Year instead of the provider's cost report year (SSI Realignment);
2. Adjustment# N/A - Effect of prior year adjustments;
3. Adjustment #35 - The DSH - SSI percentage for the inpatient rehab facility (IRF).[2]

The Medicare Administrative Contractor ("MAC") filed a formal jurisdictional challenge on August 18, 2015, stating that the Board does not have jurisdiction over issues 1, 2, and 3. The MAC contends that the Provider's appeal issues for the SSI Realignment and "effect from prior year adjustments" are not in compliance with Medicare regulations and Board Rules. In addition,

[1] Provider's Request for Appeal (Aug. 18, 2014), PRRB Case No. 14-3960.
[2] MAC's Jurisdictional Challenge, at 1 (Aug. 18, 2015).

the IRF SSI percentage is part of the LIP adjustment which is precluded from administrative and judicial review per 42 C.F.R § 412.630. The MAC requests that the Board dismiss the issues.

The Provider filed a response on September 14, 2015, arguing that the issues and potential payment include a sufficient amount to support jurisdiction by the Board. The Provider notes that it has elected to withdraw Issue 3, the IRF issue.[3]

Finally, on July 25, 2019, the MAC issued a Revised Notice of Amount of Medicare Program Reimbursement ("RNPR") concerning the SSI Realignment Issue (Issue 1), under appeal.

MAC's Contentions

Issue 1: DSH – SSI Percentage shift year calculation period (SSI Realignment)

The Provider contends that it is entitled to use data from its July 1, 2009, to June 30, 2010, fiscal year for purposes of calculating its DSH percentage rather than the data used by the MAC from the two federal fiscal year (October 1, 2009 to September 30, 2010). The Provider claimed that it has preserved its appeal rights by filing this issue under the protested items.[4]

First, the MAC contends that the Provider did not follow the Program manual instructions at PRM 15-2 § 115.2 and Board Rules for filing the protested item for the realignment issue. 42 C.F.R. § 405.1835(a)(ii) requires that effective with cost reporting periods that end on or after December 31, 2008, a provider preserves its appeal right by either claimed item and audit adjustment in NPR or included the issue as a protested item. It clearly states that, when filing the protested item, the provider should be "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 (for example, if the intermediary lacks discretion to award the reimbursement the provider seeks for the item(s))…."[5]

The MAC recognizes that, in the as-filed cost report, the Provider protested the SSI realignment issue and used a "place-holder" of "10k" as the estimated amount in controversy as "no calculation of estimated settlement impact is available since there is insufficient information to make a calculation at this time." However, the MAC contends that the "protested item" is a not merely a "place-holder" for the Provider and the Provider should have performed its due diligence to request and analyze the MEDPAR data from CMS to apply reasonable methodology which closely approximates the actual effect of the item as required in PRM 15-2 § 115.2.

Second, the MAC has not made a determination on the realignment of the SSI percentage to the hospital fiscal year end. In accordance with 42 C.F.R. §405.1835 (2005), "The provider ... has a right to a hearing before the Board about any matter designated in §405.1801 (a)(1), if ... [a]n

[3] Provider's Response to MAC's Jurisdictional Challenge, at 9 (Sep. 14, 2015).
[4] MAC's Jurisdictional Challenge, at 2.
[5] *Id*.

intermediary determination has been made with respect to the Provider." In this case, there was no final determination made by the MAC, and the Provider's protested item is not properly filed. Realignment is a remedy the Provider may pursue if it is dissatisfied with the MED PAR SSI data. Therefore, the Provider's appeal is premature.

Issue 2: Effect of Prior Year Adjustments

In the Provider's appeal request, the Provider states:

> The resolution of issues by the Provider on appeal regarding adjustments made in previous years or resulting from reopenings that occurred or still could occur are reasonably believed to affect the amount of program reimbursement that the Provider should [have] received in FY 2010 .... The Provider reasonably believes that the amount of program reimbursement at issue is in excess of the $10,000 threshold for appeals. However, the Provider is not able to specifically calculate the amount in controversy because the amount in controversy will be dependent upon the resolution of appeals currently pending from NPRs issued in earlier years and reopenings of such NPRs, if any.[6]

The MAC contends that the Provider is not appealing any *specific* adjustment in the NPR but instead is seeking to preserve its future appeal rights of this NPR in case something were to occur in the preceding years' NPRs. Appeal regulations do not allow providers to file an appeal to preserve future appeal rights of ambiguous potential issue. The issue itself as stated by the provider "Effect of prior year adjustments" indicates no dispute of the NPR it has appealed here.[7]

The MAC contends that the Provider has clearly failed to adequately identify their dispute as a specific issue. The provider fails to follow Board rule 7.1., Rule 7.1 - NPR or Revised NPR Adjustments:

> A. Identification of Issue
>
> Give a concise issue statement describing:
>
> • the adjustment, including adjustment number,
>
> • why the adjustment is incorrect, and
>
> • how the payment should be determined differently.

The MAC asserts that the Provider's statement is vague instead of concise. The Provider should have performed its due diligence to identify what items in the current year cost report are in dispute that are being impacted by the pending previous years cost reports under appeal or

[6] *Id*. at 3.
[7] *Id*. at 4.

reopening. Instead, the Provider did not submit any documentation supporting what items on the current year cost report are at issue.

The MAC also asserts that the Provider has not specified any adjustment(s) it is dissatisfied with in the NPR it disputes. The Provider neither specifies any adjustment to dispute, nor includes any issues pertaining to prior year adjustments in the protested item. Therefore, there was no final determination made. The MAC contends that the Provider did not preserve its appeal rights with this issue.

Issue 3: The DSH - SSI Percentage for the Inpatient Rehab Facility (IRF)

As the Provider withdrew this issue, the MAC's contentions will not be included.

Provider's Response

With respect to the realignment issue, the Provider contends that 42 C.F.R. § 412.106(b)(3) does not include a timing requirement for the submission of the realignment request and that Board Rules regarding the appeal of protested items do not include any timing requirements beyond the need to file an item under protest on the filed cost report. The Provider maintains that it properly requested the DSH realignment calculation, properly appealed a MAC final determination regarding this issue. As a result, the Provider maintains that this issue is properly under the Board's jurisdiction.[8]

With regard to the "flow-through" issue (i.e., the appeal of the effect in FY 2010 from certain adjustments and re-openings for prior years), the Provider observed the MAC's failure to implement such "flow-through" effect adjustments automatically or through re-openings without the Provider having appealed such issue. Based upon this MAC practice, the Provider appealed the *potential* understatement of the Provider's FY 2010 reimbursement as a result of those adjustments and re-openings.

The Provider disputes the MACs assertion that the Provider "is not appealing any specific adjustment in the NPR." Rather, the Provider maintains that it has identified a specific cost report issue with as clear of a statement of the issue in dispute as is possible given the nature of the appeal issue. The Provider further noted that the time periods for Provider-requested or MAC initiated reopenings for a prior year have not yet expired.

As explained in its appeal request, the Provider maintains that it does not have access to the information necessary to more specifically describe the MAC's adjustments because future events, such as certain resolutions and potential re-openings, could affect such underlying data. Accordingly, the Provider's appeal should be found compliant with Board Rule 7.1 under these circumstances.[9]

[8] *Id*. at 5
[9] *Id*. at 8.

Finally, with respect to the MAC jurisdictional challenge on the IRF Medicare/Supplemental Security Income percentage, the Provider responded by electing to withdraw this issue.

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over Issue No. 1 regarding SSI Realignment, and Issue No. 2, the effect of prior year adjustments issue. The Provider withdrew Issue 3 and this withdrawal is self-effectuating upon filing that request.

SSI Realignment

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

The Board concludes that it does not have jurisdiction over the SSI Realignment issue in the appeal because there is no final determination from which the Provider is appealing, and dismisses the issue from the appeal.

Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospital's alone, which then must submit a written request to the Medicare Contractor. Without this request, it is not possible for the Medicare Contractor to have issued a final determination from which the Provider could appeal.

As the MAC noted in its challenge, it has not made a determination on the realignment of the SSI percentage to the hospital fiscal year end. Indeed, there is no evidence that the Provider has filed a proper written request for realignment of its SSI percentage pursuant to 42 C.F.R. § 412.106(b)(3). In this regard, the Board notes filing an item under protest cannot be considered a written request for realignment. In accordance with 42 C.F.R. § 405.1835 (2005), "The provider ... has a right to a hearing before the Board about any matter designated in §405.1801 (a)(1), if ... [a]n intermediary determination has been made with respect to the Provider." In this case, there was no final determination made by the MAC, and the Provider's protested item was not properly filed. Realignment is a remedy the Provider may pursue if it is dissatisfied with the MED PAR SSI data.

Finally, the issue itself has become moot and the Provider should have withdrawn the issue. This appeal was based on the original NPR. Subsequently, it appears as if the Provider did file a request for realignment because, on July 25, 2019, the MAC issued a Revised Notice of Amount of Medicare Program Reimbursement ("RNPR") concerning the SSI Realignment Issue (Issue 1), under appeal.

Based on the above, the Board hereby dismisses the SSI Realignment issue.

Effect of Prior Year Adjustments

The Board dismisses the "flow-through" issue as being in violation of 42 C.F.R. § 405.1835 and Board Rules.

A provider is entitled to a hearing before the Board if (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[10] The related regulations and Board Rules describe in more detail a provider's right to Board hearing and what is required in order to file a hearing request with the Board. 42 C.F.R. § 405.1835(a) addresses a provider's right to Board hearing as follow, in pertinent part:

> (a) *Right to hearing on final contractor determination*. A provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items claimed for a cost reporting period covered by a final contractor or Secretary determination if—
>
> (1) The provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific item(s) at issue, by either—
>
> (i) Including a claim for 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 (for example, if the contractor lacks discretion to award the reimbursement the provider seeks for the item(s)).

42 C.F.R. § 405.1835(b) addresses the contents of a request for Board hearing and states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the Board, and the request **must include** the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider

[10] 42 U.S.C. § 1395oo(a).

> submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) An explanation (for **each** specific item at issue, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the contractor's or Secretary's determination under appeal, including an account of all of the following:
>
> (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item.
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.

Board Rule 7 (Mar. 1, 2013) states: "For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction." Board Rule 7.1(A) requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[11] Alternatively, if the Provider does not have access to the underlying information, it must describe why that information is not available.[12] These requirements are reiterated in Model Form A, the Individual Appeal Request form, which was utilized by the Provider to file its appeal.[13] Model Form A provides that:

> The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence

[11] *Id.* at 7.1A.
[12] *Id*. at 7.1B.
[13] *See* Model Form A, PRRB Board Rules, at 48-51.

> required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).[14]

The Provider did not appeal a specific issue, but rather a "flow-through effect" from any prior appeals. The Board recognizes that, in the appeal request, the Provider asserts that it does not have access to the information necessary to more specifically describe the MAC's adjustments because future events, such as certain resolutions and potential re-openings, could affect such underlying data. However, the stated issue is too nebulous and ambiguous. The Provider did not cite to any audit adjustments, protested items (*see* 42 C.F.R. § 405.1835(a)(1)(ii)),[15] describe what "flow-through effects" it was referring to (*e.g*., GME prior year or penultimate year), or specify which determination(s)/issue(s) from other appeals it was referring to. The Provider still must identify which "flow through" effects it is appealing. Finally, it is clear that, notwithstanding the directive in 42 C.F.R. § 405.1835(a)(1)(ii), the Provider failed to protest the "flow through" issue with associated supporting documentation as described in the Provider Reimbursement Manual, CMS Pub. 15-2, § 115.

In summary, the Board finds that the Provider failed to identify the issue that is in dispute, in violation of 42 C.F.R. § 405.1835 and the Board Rules. The Board thus dismisses the issue for lack of specificity as required by § 405.1835(b) and Board Rule 7.1(A).

DSH - SSI Percentage for the Inpatient Rehab Facility (IRF)

This issue was withdrawn by the Provider.

In summary, the Board denies jurisdiction over Issue 1 and issue 2. Issue 3 was withdrawn. As there are no remaining issues, the case is now closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/31/2020

X Clayton J. Nix

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

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

[14] *Id*. at 50. (Section 8 of Model Form A describes the requirements for appealed issues).
[15]