DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

David Cohan
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RE: ***EJR Determination***
14-0100GC – *QRS BJC 2008 DSH SSI Fraction/Dual Eligible Days CIRP Group*
14-0103GC – *QRS BJC 2008 DSH Medicaid Fraction/Dual Eligible Days CIRP Group*
14-1299GC – *QRS BJC 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
14-1301GC – *QRS BJC 2009 DSH SSI Fraction Dual Eligible Days CIRP Group*
14-3837GC – *QRS BJC 2011 DSH SSI Fraction Dual Eligible Days CIRP Group*
14-3839GC – *QRS BJC 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
15-0645GC – *QRS BJC 2010 DSH SSI Fraction Dual Eligible Days CIRP Group*
15-0647GC – *QRS BJC 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
15-2588GC – *QRS BJC 2012 DSH SSI Fraction Dual Eligible Days CIRP Group*
15-2589GC – *QRS BJC 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
17-0835GC – *QRS BJC 2013 DSH SSI Fraction Dual Eligible Days CIRP Group*
17-0836GC – *QRS BJC 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Gro*up
18-0962GC – *QRS BJC 2014 DSH SSI Fraction Dual Eligible Days CIRP Group*
18-0965GC – *QRS BJC 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
18-1531GC – *QRS BJC 2015 DSH SSI Fraction Dual Eligible Days CIRP Group*
18-1532GC – *QRS BJC 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group*
19-0739GC – *BJC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group*
19-0741GC – *BJC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group*

Dear Mr. Cohan:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 24, 2022 request for expedited judicial review ("EJR") in the above-referenced eighteen (18) common issue related party ("CIRP") group appeals involving BJC Healthcare. The decision of the Board 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 March 22, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these 18 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 March 22, 2022, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

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

For each year at issue, BJC Healthcare established two CIRP groups with one CIRP group addressing the "SSI Fraction/Dual Eligible Days" issue and the other addressing the "Medicaid Fraction/Dual Eligible Days" issue.

In their group issue statement for the "SSI Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
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> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead 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.
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> **Statement of Legal Basis**
>
> The Provider contends that the Lead 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 Lead 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.
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> 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).
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> 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(s) contend(s) 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.
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> It is the Providers' contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.[1]

Similarly, in their group issue statement for the "Medicaid Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead 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.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Lead 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

[1] *E.g.*, Group Issue Statement for Case 14-0100GC.

> calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Lead 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.
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> 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(s) contend(s) 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.[2]

While the two issue statements are essentially the same, the Board required the formation of two separate groups for each year as there are two legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group for the "SSI Fraction/Dual Eligible Days" issue challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). The Board views the EJR request as a consolidated request encompassing both CIRP groups for each of the years at issue.

[2] *E.g.*, Group Issue Statement for Case 14-0103GC.

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").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

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

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

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

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

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

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

> 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.[12]

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

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.[14] 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.[15]

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."[16] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[17] The Secretary then summarized his 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."[18]

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *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).[19] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[20] 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.[21]

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.[22] 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.[23] 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. [24] 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.[25]

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.[26] 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."[27]

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.[28]

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[19] *Id.* at 27207-08.
[20] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[21] 68 Fed. Reg. at 27208.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[27] *Id.*
[28] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

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.[29]
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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*.[30]

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."[31] 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."[32] Prior to this revision, § 412.106(b)(2) (2004) had stated:

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[29] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[30] *Id.* at 49099 (emphasis added).
[31] *Id.*
[32] *See id.* at 49099, 49246.

> (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 . . .[33]

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 . . .[34]

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."[35]

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*"),[36] 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.[37] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures

[33] (Emphasis added.)
[34] (Emphasis added.)
[35] *Id.*
[36] 317 F. Supp. 3d 168 (D.D.C. 2018).
[37] *Id.* at 172.

and that the rule is *not* procedurally defective.[38] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[39] 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.[40] 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*"),[41] 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*,[42] 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.[43]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[44] 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."[45] 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.[46] 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 context 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[47] and that the regulation is procedurally invalid.[48]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[49] 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.[50] Rather, the Ninth Circuit found that this revision "was a

[38] *Id.* at 190.
[39] *Id.* at 194.
[40] *See* 2019 WL 668282.
[41] 718 F.3d 914 (2013).
[42] 657 F.3d 1 (D.C. Cir. 2011).
[43] 718 F.3d at 920.
[44] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[45] *Id.* at 1141.
[46] *Id.*
[47] *Id.* at 1162.
[48] *Id.* at 1163
[49] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[50] *Id.* at 884.

logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[51] 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*")[52] 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."[53] 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."[54] 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."[55] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[56] Thus, 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' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these no-pay Part A days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Provider's further contend that the unambiguous language of the Medicare Act mandates exclusion of no-

[51] *Id.* at 884.
[52] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[53] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[54] *Id.* at 886.
[55] *Id.*
[56] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

pay Part A days from the Medicare fraction. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above). Finally, the Providers contend that the unambiguous language of the Medicare Act mandates inclusion of no-pay Part A days in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible.

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of no-pay Part A days in the Medicare fraction are illegal and that such days must be included in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

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. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

All of the participants in the following 16 CIRP groups appealed cost reporting periods beginning prior to January 1, 2016: Case Nos. 14-0100GC, 14-0103GC, 14-1299GC, 14-1301GC, 14-3837GC, 14-3839GC, 15-0645GC, 15-0647GC, 15-2588GC, 15-2589GC, 17-0835GC, 17-0836GC, 18-0962GC, 18-0965GC, 18-1531GC, 18-1532GC.

1. Statutory and Regulatory Background

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[57] 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.[58]

[57] 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.).
[58] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[59] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[60] 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.[61]

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.

2. Dismissal of the Participant, Christian Hospital (Prov. No. 26-0180, FYE 12/31/2009), from Case Nos. 14-1299GC and 14-1301GC

In Case Nos. 14-1299GC and 14-1301GC, Christian Hospital (Provider No. 26-0180) appealed from a Revised NPR dated July 13, 2016 for its fiscal year ending December 31, 2009 ("FY 2009). However, as set forth below, the Board is dismissing Christian Hospital from these two CIRP groups because the Revised NPR did not specifically adjust dual eligible days as required by 42 C.F.R. § 405.1887(b).

The Code of Federal Regulations provides for an opportunity for a reopening and a Revised NPR at 42 C.F.R. § 405.1885 (2009), 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

[59] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[60] 201 F. Supp. 3d 131 (D.D.C. 2016).
[61] *Id.* at 142.

> contractor (with respect to contractor determinations), or by the reviewing entity that made the decision . . . .

Additionally, 42 C.F.R. § 405.1889 (2009)[62] 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.

Here, the jurisdictional documentation for Christian Hospital that was submitted in the Schedule of Providers for these two CIRP group cases establishes the following:

- On November 11, 2015, the Provider requested the Medicare Contractor to reopen the FY 2009 cost report because it was "requesting additional Medicaid days to be included in the Disproportionate Share calculation and in the IRF LIP calculation."

- The Medicare Contractor workpaper dated March 17, 2016 states that the Provider was claiming 328 additional Medicaid eligible days to be included in the Medicaid fraction of the DSH adjustment (and 32 Medicaid eligible days to be included in the LIP adjustment). The workpaper establishes that the Medicare Contractor planned to adjust the Medicaid fraction by adding an additional 310 days and, as a result of that change, would increase the DSH payment percentage to 10.48 percent.

- The Worksheet E, Part A, prepared July 7, 2016 for calculation of reimbursement settlement shows that the DSH payment percentage was to be increased to 10.46 percent.

- The Audit Adjustment Report dated July 7, 2016, shows Audit Adjustment 6 "[t]o adjust the DSH % based on additional Medicaid days" resulting in the DSH payment percentage being increased to 10.46. This was change was based on Audit Adjustment 5 "[t]o include additional Medicaid days found allowable during review" which was 310 days.

[62] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

The Board has reviewed the cited audit adjustments and determined that none of them specifically revise Exhausted Part A (Dual Eligible) days in the SSI or Medicaid fractions.[63] As such, the Board hereby dismisses Christian Hospital (Provider No. 26-0180) from Case Nos. 14-1299GC and 14-1301GC.

*3. Jurisdiction for the **Remaining** Participants Appealing Cost Report Periods Beginning Prior to January 1, 2016 (i.e., the remaining participants in Case Nos. 14-0100GC, 14-0103GC, 14-1299GC, 14-1301GC, 14-3837GC, 14-3839GC, 15-0645GC, 15-0647GC, 15-2588GC, 15-2589GC, 17-0835GC, 17-0836GC, 18-0962GC, 18-0965GC, 18-1531GC, 18-1532GC*

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in each of these CIRP group cases covering CYs 2008 through 2015 are governed by the ruling in *Bethesda* or CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[64] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP group appeals covering CYs 2008 through 2015 and the remaining participants therein.

B. Appeals of Cost Report Periods Beginning On or After January 1, 2016

All of the participants in Cases Nos. 19-0739GC and 19-0741GC appealed cost report periods beginning on January 1, 2016 and the participants in each of these 2 groups are the same.

1. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[65] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[66] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the

[63] Per the FY 2005 IPPS Final Rule, dual eligible days are not counted in the Medicaid fraction and must be counted in the SSI fraction, even in situations involving exhausted days and other no-pay days. Here, it is clear that the SSI fraction (where, per the FY 2005 IPPS Final Rule, no-pay Part A days ***are*** included in the denominator) was not adjusted in the Revised NPR. Accordingly, the addition of 310 Medicaid eligible days to the Medicaid fraction in the Revised NPR did not specifically revise or otherwise impact the no-pay Part A days at issue.
[64] *See* 42 C.F.R. § 405.1837.
[65] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[66] *Id.* at 70555.

MAC or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As all of the participants in these 2 CIRP group appeals have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise these 2 CIRP group appeals have filed appeals involving fiscal years 2016. Based on its review of the record, the Board finds that each of the participants in these 2 CIRP groups filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

2. *Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 (Cost Reports Beginning on or After January 1, 2016*

For cost report periods beginning on or after January 1, 2016, the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The regulation, 413.24(j) requires that:

> (1) In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.

> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

In conjunction with the regulation above, 42 C.F.R. § 405.1873(a) states:

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item (as prescribed in § 413.24(j) of this chapter). **If** the provider files an appeal to the Board seeking reimbursement for the specific item and **any party** to such appeal **questions whether the provider's cost report included an appropriate claim for the specific item**, the Board must address such question in accordance with the procedures set forth in this section.

These regulations are applicable to the cost reporting periods under appeal for all of the providers in Cases Nos. 19-0739GC and 19-0741GC, which all have cost reporting periods ending December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[67] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[68] In these two

[67] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[68] *See* 42 C.F.R. § 405.1873(a).

CIRP group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[69] within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers with FYEs December 31, 2016.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[70] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis of the Appealed Issue

The 18 CIRP group appeals in these EJR requests involve the 2008 to 2016 cost reporting periods and the 2 CIRP groups for each year involve the ***same*** participants. 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder*. . . ."[71] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible. In the alternative, the Providers request that these no-pay Part A days simply not be counted in either fraction, *i.e.,* that, consistent with the 9th Circuit's decision in *Empire*, the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only "covered" patient days be reinstated so that the days at issue are not counted in either fraction.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy finalized in the FY 2005 IPPS Final Rule does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard,

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[69] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[70] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[71] (Emphasis added.)

the Board notes that it is clear that the *class of patients* who are dual eligibles do, in fact, have Medicare Part A (*i.e.*, they are enrolled in 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*** or covered under the Medicare Part A and were "entitled" to Part A benefits).[72] To this end, the Providers are asserting that only in certain ***no-pay*** Part A situations involving dual eligible beneficiaries (*e.g.*, exhausted benefits and MSP) must the 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 Part A 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*")[73] and CMS Ruling 1498-R2 wherein multiple possible treatments of no-pay dual eligible days are discussed. Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[74] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the legal argument in the set of CIRP groups for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument in the set of CIRP groups for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the EJR request as a consolidated request involving the two sets of CIRP groups at issue for CYs 2008 to 2016.

D. 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 Providers in these 18 CIRP group appeals are entitled to a hearing before the Board with one exception, namely the Board lacks jurisdiction over Christian Hospital (Prov. No. 26-0180, FYE 12/31/2009) in Case Nos. 14-1299GC and 14-1301GC and dismisses Christian Hospital from those two CIRP groups;

---

[72] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

[73] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

[74] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

2) Based upon the *remaining* Providers' assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final 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 the authority to decide the legal question of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the *remaining* Providers' request for EJR for the issue and the subject years.[75] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Everts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

4/1/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS

[75] Pursuant to 42 C.F.R. § 405.1842(b)(1), jurisdiction is a pre-requisite to Board consideration of EJR. As the Board lacked jurisdiction over Christian Hospital in Case Nos. 14-1299GC and 14-1301GC and dismissed Christian Hospital from these cases, Christian Hospital was not eligible for Board consideration of potential EJR.

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: ***EJR Determination***
13-3894GC QRS BHCS 2008 DSH Medicaid Fraction/Dual Eligible Days CIRP Group
13-3896GC QRS BHCS 2007 DSH Medicaid Fraction/Dual Eligible Days CIRP Group
13-3932GC QRS BHCS 2008 DSH SSI Fraction/Dual Eligible Days CIRP Group
13-3938GC QRS BHCS 2007 DSH SSI Fraction/Dual Eligible Days Group
14-2894GC QRS BHCS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2896GC QRS BHCS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP
15-0356GC QRS BHCS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0358GC QRS BHCS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0734GC QRS BHCS 2011 DSH SSI Faction Dual Eligible Days CIRP Group
15-0735GC QRS BHCS 2011 DSH Medicaid Dual Eligible Days CIRP Group
15-3167GC QRS BSWH 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-3170GC QRS BSWH 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-1535GC QRS BSWH 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1536GC QRS BSWH 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 4, 2022 request for expedited judicial review ("EJR") in the above-referenced fourteen (14) common issue related party ("CIRP") group appeals involving BHCS. The decision of the Board 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 March 29, 2022, the Board sent the Group Representative notice that the 30-day time period for issuing an EJR had been stayed for these 14 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 March 22, 2022, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access

to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

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

For each year at issue, BHCS established two CIRP groups with one CIRP group addressing the "SSI Fraction/Dual Eligible Days" issue and the other addressing the "Medicaid Fraction/Dual Eligible Days" issue.

In their group issue statement for the "SSI Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead 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.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Lead 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 Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused 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(s) contend(s) 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 Providers' contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.[1]

Similarly, in their group issue statement for the "Medicaid Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead 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.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Lead 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 Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days

[1] *E.g.*, Group Issue Statement for Case 13-3932GC.

> in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused 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(s) contend(s) 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.[2]

While the two issue statements are essentially the same, the Board required the formation of two separate groups for each year as there are two legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group for the "SSI Fraction/Dual Eligible Days" issue challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). The Board views the EJR request as a consolidated request encompassing both CIRP groups for each of the years at issue.

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

[2] *E.g.*, Group Issue Statement for Case 13-3894GC.

inpatient prospective payment system ("IPPS").[3] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[4]

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

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

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

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

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

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

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

> Medicaid program], but who were *not entitled to benefits under part A of this subchapter,* and the denominator of which is the total number of the hospital's patient days for such period.[12]

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

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.[14] 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.[15]

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."[16] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[17] The Secretary then summarized his 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."[18]

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).[19] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[20] to differentiate the days for dual eligible patients who Part A coverage had been

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[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(4).
[14] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[15] *Id.*
[16] *Id.*
[17] *Id.*
[18] *Id.* at 27207-27208.
[19] *Id.* at 27207-08.
[20] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

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.[21]

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.[22] 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.[23] 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. [24] 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.[25]

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.[26] 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."[27]

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.[28]
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

[21] 68 Fed. Reg. at 27208.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[27] *Id.*
[28] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> 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.[29]
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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*.[30]

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."[31] 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."[32] 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

[29] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).
[30] *Id.* at 49099 (emphasis added).
[31] *Id.*
[32] *See id.* at 49099, 49246.

> (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 . . .[33]

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 . . .[34]

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."[35]

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*"),[36] 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.[37] 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.[38] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[39] 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.[40] 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.

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

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[41] 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*,[42] 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.[43]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[44] 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."[45] 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.[46] 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 context 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[47] and that the regulation is procedurally invalid.[48]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[49] 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.[50] 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."[51] 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*")[52] 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

[41] 718 F.3d 914 (2013).
[42] 657 F.3d 1 (D.C. Cir. 2011).
[43] 718 F.3d at 920.
[44] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[45] *Id.* at 1141.
[46] *Id.*
[47] *Id.* at 1162.
[48] *Id.* at 1163
[49] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[50] *Id.* at 884.
[51] *Id.* at 884.
[52] 97 F.3d 1261, 1265-66 (9th Cir. 1996).

patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[53] 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."[54] 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."[55] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[56] Thus, 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' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these no-pay Part A days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Provider's further contend that the unambiguous language of the Medicare Act mandates exclusion of no-pay Part A days from the Medicare fraction. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above). Finally, the Providers contend that the unambiguous language of the Medicare Act mandates inclusion of no-pay Part A days in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible.

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of no-pay Part A days in the Medicare fraction are illegal and that such days must be included in the Medicaid fraction to the

[53] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[54] *Id.* at 886.
[55] *Id.*
[56] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

extent the relevant underlying patient was also Medicaid eligible. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

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. Appeals of Cost Report Periods Beginning Prior to January 1, 2016

1. Statutory and Regulatory Background

All of the participants in the 14 CIRP groups appealed cost reporting periods beginning prior to January 1, 2016. For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[57] 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.[58]

On August 21, 2008, new regulations governing the Board were effective.[59] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[60] 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

[57] 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.).
[58] *Bethesda*, 108 S. Ct. at 1258-59.
[59] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[60] 201 F. Supp. 3d 131 (D.D.C. 2016).

regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[61]

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.

2. *Case Nos. 15-3167GC and 15-3170GC — Dismissal of the Participant, Baylor Medical Center at Carrollton (Prov. No. 45-0730, FYE 9/30/2012)*

In Case Nos. 15-3167GC and 15-3170GC, the final determination for Baylor Medical Center at Carrollton (Provider No. 45-0730, FYE 9/30/2012) was dated April 24, 2015. The Board received the appeal request for each of these appeals on Wednesday, October 28, 2015. Thus, the appeal request was received 187 days after the date of the final determination.

Pursuant to 42 C.F.R. § 405.1835(a)(3) (2015), unless a provider qualifies for a good cause extension, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination. The date of receipt of a final determination is presumed to be five (5) days after the date of issuance, and the date of receipt of documents by the Board is presumed to be the date stamped "received" by the Board.[62]

Since the appeal request was received 187 days after the date of the final determination, which exceeds the 180 day appeal period (plus 5 day presumption for date of receipt of the NPR) allowed for appealing a final determination, the Board hereby dismisses Baylor Medical Center at Carrollton (Provider No. 45-0730, FYE 9/30/2012) from Case Nos. 15-3167GC and 15-3170GC.

3. *Case Nos. 13-3896GC and 13-3938GC*

a. *Dismissal of the Participant 1, Baylor Medical Center at Irving (Prov. No. 45-0079, FYE 6/30/2007), and Participant 3, Baylor Medical Center at Garland (Prov. No. 45-0280, FYE 12/31/2007,) from Case Nos. 13-3896GC and 13-3938GC*

Baylor Medical Center at Irving (Prov. No. 45-0079, FYE 6/30/2007) and Baylor Medical Center at Garland (Prov. No. 45-0280, FYE 12/31/2007) appealed from Revised NPRs dated January 26, 2013 and June 26, 2015, respectively. However, as set forth below, the Board is dismissing both

[61] *Id.* at 142.
[62] PRRB Rule 4.3 (2015 & 2018). *See also* 42 C.F.R. § 405.1801(a)(1)(iii).

Providers from these two CIRP groups because the Revised NPRs did not specifically adjust dual eligible days as required by 42 C.F.R. § 405.1889(b).

The Code of Federal Regulations provides for an opportunity for a reopening and a Revised NPR at 42 C.F.R. § 405.1885 (2007), 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 (2007) explains that:

> Where a revision is made in a determination or decision on the amount of program reimbursement after such determination or decision has been reopened as provided in §405.1885, such revision shall be considered a *separate and distinct determination or decision* . . . .[63]

The text of this regulation was addressed and explained in the 1994 decision of the U.S. Court of Appeals for the District of Columbia ("D.C. Circuit") in *HCA Health Services of Oklahoma v. Shalala*.[64] In that case, the D.C. Circuit held that when a fiscal intermediary reopens its original determination regarding the amounts of reimbursement that a Medicare provider is to receive and a provider appeals this decision, the Board's jurisdiction is limited to the specific issues revisited on reopening.[65]

Furthermore, 42 C.F.R. § 405.1889 (2008)[66] 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.

[63] (Emphasis added.)
[64] 27 F.3d 614 (D.C. Cir. 1994).
[65]
[66] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (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.

Here, the jurisdictional documentation for Baylor Medical Center at Irving submitted in the Schedule of Providers for these two CIRP group cases establishes the following:

- On October 5, 2012, the Medicare Contractor issued a Notice of Reopening "to add back L&D days and total days on W/S S-3" and "to adjust allowable DSH percentage to audited amount."[67]

- The Worksheet E, Part A, prepared October 5, 2012 for calculation of reimbursement settlement, along with Audit Adjustment No. 5 on the Audit Adjustment Report, shows that the DSH payment percentage was to be increased from 12.37 to 12.41 percent.

Similarly, the jurisdictional documentation for Baylor Medical Center at Garland that was submitted in the Schedule of Providers for these two CIRP group cases establishes the following:

- On February 3, 2015, the Medicare Contractor issued a Notice of Reopening "to correct the Medicaid days that were overstated on the audited cost report."[68]

- The Worksheet E, Part A, prepared June 17, 2015 for the calculation of reimbursement settlement shows that the DSH percentage was calculated to be 10.41 percent.

- The DSH Worksheet, prepared June 17, 2015, shows that the "percentage of SSI patient days to Medicare Part A days" and the "percentage of Medicaid patient days to total days" were both unchanged. Similarly, the "total Medicaid patient days for the DSH calculation" was originally 9,124, and the revised value remained 9,124.

- Audit Adjustment No. 4 on the Audit Adjustment Report dated June 12, 2015 shows that the DSH percentage was decreased from 10.87 percent to 10.41 percent based on the removal of 309 Adults & Pediatrics days: "To update the allowable Medicaid Days per provider's submitted documentation, and adjust allowable DSH percentage."

The Board has reviewed the cited audit adjustments and determined that none of them specifically revise Exhausted Part A (Dual Eligible) days in the either SSI fraction or the Medicaid fraction.[69] Rather, the only adjustments made in the revised NPRs at issue relate to

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[67] 13-3896GC SOP and Jurisdictional Documents at PDF page 34 (Notice of Reopening dated Oct. 5, 2012)
[68] *Id.* at PDF page 120 (Notice of Reopening dated Feb. 3, 2015).
[69] Per the FY 2005 IPPS Final Rule, dual eligible days are not counted in the Medicaid fraction and must be counted in the SSI fraction, even in situations involving exhausted days and other no-pay days. Here, it is clear that the SSI

adding Medicaid-***only*** days to the Medicaid fraction. As such, the Board hereby dismisses Baylor Medical Center at Irving (Prov. No. 45-0079) and Baylor Medical Center at Garland (Prov. No. 45-0280) from Case Nos. 13-3896GC and 13-3938GC because these Providers had no right to appeal the issues in Case Nos. 13-3896GC and 13-3938GC under 42 C.F.R. § 405.1889 as referenced in 42 C.F.R. § 405.1835(a)(1). The Board notes that recent decisions of the D.C. District Court have upheld the Board's application of 42 C.F.R. 405.1889(b).[70]

b. Dismissal of the Participant 5, Baylor Medical Center at Waxahachie (Prov. No. 45-0372, FYE 6/30/2008), from Case No. 13-3896GC

Baylor Medical Center at Waxahachie (Prov. No. 45-0372, FYE 6/30/2007) is Participant 5 in the CIRP groups under Case No. Case No. 13-3896GC entitled "QRS BHCS 2007 DSH Medicaid Fraction/Dual Eligible Days CIRP Group" and Case No. 13-3836GC entitled "QRS BHCS 2007 DSH SSI Fraction/Dual Eligible Days CIRP Group" based on its appeal of the revised NPR dated December 30, 2015. As discussed *infra* in Subsection B, the issue covered in in Case No. 13-3938GC addressing the exclusion of no-pay Part A days from the SSI fraction is separate and distinct from the issue in Case No. 13-3896GC addresses the inclusion of certain dual eligible days in the Medicaid fraction of the DSH calculation. Baylor Medical Center at Waxahachie appealed from a Revised NPR dated December 30, 2015. However, as set forth below, the Board is dismissing Baylor Medical Center at Waxahachie from Case No. 13-3896GC because the Revised NPR at issue did not specifically adjust dual eligible days in the Medicaid fraction as required by 42 C.F.R. § 405.1889(b).

The jurisdictional documentation for Baylor Medical Center at Waxahachie submitted in the Schedule of Providers for these two CIRP group cases is essentially identical and establishes the following:

- On December 22, 2015, the Medicare Contractor issued a Notice of Intent to Reopen "in the event of an unfavorable final non-appealable decision in Allina Health Services v. Sebelius" in order "to adjust the Disproportionate Share payment calculation."[71]

- The Audit Adjustment Report issued with the December 30, 2015 revised NPR is dated December 22, 2015 and Audit Adjustment 5 and 6 were cited in the appeal request:

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fraction (where, per the FY 2005 IPPS Final Rule, no-pay Part A days ***are*** included in the denominator) was not adjusted in the Revised NPR. Accordingly, any changes to the number of Medicaid eligible days to the Medicaid fraction in the Revised NPR did not specifically revise or otherwise impact the no-pay Part A days at issue.

[70] *St. Mary's of Mich. v. Azar*, No. 1:18-cv-01790, 2020 WL 4049912 (D.D.C. July 20, 2020) (upholding Board dismissal of DSH dual eligible days issue where the appeal was based on a revised NPR that only adjusted the DSH adjustment to add Medicaid eligible days to the Medicaid fraction); *Flint v. Azar*, 464 F. Supp. 3d 1 (D.D.C. 2020) (upholding Board dismissal of DSH Part C Days issue where the appeal was based on a revised NPR that only adjusted the DSH adjustment to add Medicaid eligible days to the Medicaid fraction); Emanuel Med. Ctr., Inc. v. Sebelius, 37 F. Supp. 3d 348 (D.D.C. 2014) (upholding Board dismissal of SSI fraction issue where the appeal was based on a revised NPR that only adjusted the DSH adjustment to add Medicaid-only days to the Medicaid fraction).

[71] 13-3896GC SOP and Jurisdictional Documents at PDF page 207 (Notice of Reopening dated Dec. 22, 2015).

- Adjustment No. 5 "To adjust the SSI ratio to the latest amount released by CMS" wher the SSI percentage was decreased from 5.79 to 5.72

- Adjustment No. 6 "To adjust the DSH percentage per the audited calculation using the updated SSI ratio" where the DSH percentage was increased from 9.52 to 9.70[72]

- The HCRIS report shows that the revised NPR only adjusted the DSH percentage and the SSI percentage and that no changes were made to Medicaid eligible days.[73]

The Board has reviewed the cited audit adjustments and determined that none of them specifically revise Exhausted Part A (Dual Eligible) days in the ***Medicaid*** fraction.[74] Rather, the only adjustments made in the revised NPRs at issue relate to the SSI fraction and, as such, jurisdiction is limited to the issue Case No. 13-3836GC relating to the exclusion of no-pay Part A days from the SSI fraction. As such, the Board hereby dismisses Baylor Medical Center at Waxahachie from Case Nos. 13-3896GC because these Providers had no right under 42 C.F.R. § 405.1889 (as referenced in 42 C.F.R. § 405.1835(a)(1)) to appeal the issue in Case No. 13-3896GC pertaining to the inclusion of no-pay dual eligible days in Medicaid fraction issue. The Board again notes that recent decisions of the D.C. District Court have upheld the Board's application of 42 C.F.R. 405.1889(b).[75]

*4. Jurisdiction for the **Remaining** Participants Appealing Cost Report Periods Beginning Prior to January 1, 2016*

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in each of these CIRP group cases covering CYs 2007 through 2013 are governed by the ruling in *Bethesda* or CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[76] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP group appeals covering CYs 2007 through 2013 and the remaining participants therein.

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[72] *Id.* at PDF page 200 (the Audit Adjustment report is located in the data file at: H:\FY 2016\Hospitals\Reopenings\450372_06302007_R1\Final\FO_450372_06302007.mca).
[73] *Id.* at PDF page 203 (Line 1 includes the SSI percentage and DSH percentage included in the revised NPR and a comparison of Line 1 to Line 2 demonstrates that only the SSI percentage and DSH percentage were adjusted and that Medicaid days was not adjusted).
[74] Per the FY 2005 IPPS Final Rule, dual eligible days are not counted in the Medicaid fraction and must be counted in the SSI fraction, even in situations involving exhausted days and other no-pay days. Here, it is clear that the SSI fraction (where, per the FY 2005 IPPS Final Rule, no-pay Part A days ***are*** included in the denominator) was adjusted in the Revised NPR. However, the Medicaid fraction was not adjusted (and, even it had been, it would have only related to Medicaid eligible days consistent with CMS policy).
[75] *See supra* note 70.
[76] *See* 42 C.F.R. § 405.1837.

B. Board's Analysis of the Appealed Issue

The 14 CIRP group appeals in these EJR requests involve the 2007 to 2013 cost reporting periods and the 2 CIRP groups for each year involve the ***same*** participants. 42 C.F.R. § 405.1867 specifies that "[i]n exercising its authority to conduct proceedings under this subpart, the Board ***must*** *comply with* all the provisions of Title XVIII of the Act and *regulations issued thereunder* . . . ."[77] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the *subset* of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintain in their EJR request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated (either procedurally or substantively) and that, instead of reverting back to the prior policy of the Secretary under which such days were counted in neither fraction, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible. In the alternative, the Providers request that these no-pay Part A days simply not be counted in either fraction, *i.e.,* that, consistent with the 9th Circuit's decision in *Empire*, the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only "covered" patient days be reinstated so that the days at issue are not counted in either fraction.

As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy finalized in the FY 2005 IPPS Final Rule does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that it is clear that the *class of patients* who are dual eligibles do, in fact, have Medicare Part A (*i.e.*, they are enrolled in 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*** or covered under the Medicare Part A and were "entitled" to Part A benefits).[78] To this end, the Providers are asserting that only in certain ***no-pay*** Part A situations involving dual eligible beneficiaries (*e.g.*, exhausted benefits and MSP) must the 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 Part A 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*")[79] and

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[77] (Emphasis added.)
[78] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[79] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

CMS Ruling 1498-R2 wherein multiple possible treatments of no-pay dual eligible days are discussed. Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[80] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, the Providers would be arguing that the prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the legal argument in the set of CIRP groups for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument in the set of CIRP groups for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the *subset* of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the EJR request as a consolidated request involving the two sets of CIRP groups at issue for CYs 2007 to 2013.

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 Providers in these 14 CIRP group appeals are entitled to a hearing before the Board with the following exceptions:

    a. The Board lacks jurisdiction over Baylor Medical Center at Carrollton (Prov. No. 45-0730, FYE 9/30/2012) in Case Nos. 15-3167GC and 15-3170GC and dismisses Baylor Medical Center at Carrollton from those two CIRP groups;

    b. The Board lacks jurisdiction over Baylor Medical Center at Irving (Prov. No. 45-0079, FYE 6/30/2007) and Baylor Medical Center at Garland (Prov. No. 45-0280, FYE 12/31/2007) in Case Nos. 13-3896GC and 13-3938GC and dismisses them from those two CIRP groups;

    c. The Board lacks jurisdiction over Baylor Medical Center at Waxahachie (Prov. No. 45-0372, FYE 6/30/2008) in Case No. 13-3896GC and dismisses it from this CIRP group;

2) Based upon the *remaining* Providers' assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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[80] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

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) (as modified by the FY 2005 IPPS Final Rule) is valid and, if successful, what policy should then apply which necessarily would determine the appropriate relief, namely whether to simply exclude such non-covered Part A days from both the SSI and Medicaid fraction (as was done prior to the FY 2005 IPPS Final Rule) or to count only those non-covered Part A days involving patients who are also eligible Medicaid in the Medicaid fraction.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the *remaining* Providers' request for EJR for the issue and the subject years.[81] The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

4/13/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

Enclosure: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions (J-H)
Wilson Leong, FSS

[81] Pursuant to 42 C.F.R. § 405.1842(b)(1), jurisdiction is a pre-requisite to Board consideration of EJR. As the Board lacked jurisdiction over Baylor Medical Center at Carrollton in Case Nos. 15-3167GC and 15-3170GC, Baylor Medical Center at Irving and Baylor Medical Center at Garland in Case Nos. 13-3896GC and 13-3938GC, and Baylor Medical Center at Waxahachie in Case No. 13-3896GC; and dismissed these providers from these cases, they were not eligible for Board consideration of potential EJR.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

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RE: ***Determination on Expansion of CIRP Group to Meet Amount In Controversy Threshold***

HRS DCH 2014 DSH SSI Fraction Dual Eligible Days CIRP Group, Case No. 17-1740GC[1]

DCH 2015 DSH SSI Fraction Dual Eligible Days CIRP Group, Case No. 21-0971GC

DCH Regional Medical Center (01-0092) FYE 9/30/2011, Case No. 20-1606

Dear Mr. Ravindran and Ms. Huggins:

On March 28, 2022, the Provider Reimbursement Review Board (the "Board") issued a Request for Information ("RFI") requesting the Parties' comments regarding an earlier proposal to consolidate the subject calendar year ("CY") 2014 common issue related party ("CIRP") group, Case No. 17-1740GC, into a reopened and expanded CY 2015 Dual Eligible Days CIRP group, Case No. 21-0971GC.[2] The consolidation was proposed in order to resolve the issue that Case No. 17-1740GC failed to meet the $50,000 amount in controversy threshold. Because the two groups involved different Group Representatives, the Board also required an updated authorization letter, designating the Representative for the surviving group.

On April 8, 2022, Quality Reimbursement Services, Inc. ("QRS") was appointed as the Group Representative for Case No. 17-1740GC, replacing HRS. On April 11, 2022, QRS filed its response to the Board's RFI, in which it concurred with the Board's proposal to expand the later year CIRP group under Case No. 21-0971GC. On the same date, QRS rescinded its April 11, 2022 RFI response and resubmitted a revised response the following day. In its April 12, 2022 correspondence, QRS not only agreed with the Board's proposal to reopen the status of Case No. 21-0971GC in order to expand and consolidate the CY 2014 CIRP group Case No. 17-1740GC, it also requested that an additional CY be included in the group. According to QRS

[1] The group name includes the abbreviation of the representative that filed the group, Hospital Reimbursement Services, Inc. ("HRS").
[2] Case No. 21-0971GC was designated to be fully formed on March 4, 2022 in the Office of Hearings Case & Document Management System ("OH CDMS").

there is an additional provider, DCH Regional Medical Center (01-0092), for CY 2011 that is appealing the SSI Fraction Dual Eligible Days issue in an individual appeal under Case No. 20-1606.[3] Therefore, QRS proposed that the Board expand the CY 2015 CIRP group under Case No. 21-0971GC to include CY 2011, as well as CY 2014. QRS certified that there are no relevant factual or regulatory changes for the DSH SSI Fraction Dual Eligible Days issue between CYs 2011 through 2015.

Board Determination:

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

Board Rule 12.5 indicates that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end with the same calendar year. However, groups may submit a written request to include more than one calendar year to meet the minimum number of providers . . . ".[4] In addition, "[o]ne or more of the providers bringing a group appeal . . . **subject to the Board's discretion**, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes. . . ".[5] (emphasis added) With regard to the number of Providers in a fully formed CIRP group, 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1. provide that a single provider under common ownership or control may initiate a Common Issue Related Party ("CIRP") group, **but require that at least two different providers be in the group upon full formation**.

After a review of the CYs 2014 and 2015 SSI Fraction Dual Eligible Days CIRP groups, the Board agrees to reopen the status of Case No. 21-0971GC in order to consolidate the two years in order to meet the $50,000 group threshold. Additionally, the Board agrees to allow Case No. 21-0971GC to be further expanded to include CY 2011. The group name is being modified to "DCH CYs 2011 & 2014 - 2015 DSH SSI Fraction Dual Eligible Days CIRP Group."

With the consolidation of Case No. 17-1740GC into Case No. 21-0971GC there are no remaining participants in the CY 2014 CIRP group. Therefore, Case No. 17-1740GC is hereby closed and removed from the Board's docket.

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[3] Case No. 20-1606 was created by the Board on May 4, 2020 when it was determined that DCH Regional Medical Center was the sole participant in the DCH Health CY 2011 DSH SSI Fraction Dual Eligible Days CIRP Group under Case No. 19-1798GC. Prior to the Board agreeing to the creation of the individual appeal, QRS certified that there were no other DCH providers pursuing the issue for CY 2011. Case No. 20-1606 also includes three additional issues from other single participant groups that were also disbanded.

[4] Board Rules (Aug. 29, 2018; revised Nov. 1, 2021)

[5] 42 C.F.R. § 405.1837(b)(ii).

Because Case No. 20-1606 is fully populated in OH CDMS, QRS is advised that, within 15 days of the signature date of this notification, it must effectuate the transfer of the SSI Fraction Dual Eligible Days issue from the individual appeal to Case No. 21-0971GC by using the "Transfer" button in OH CDMS.[6] Upon completion of the transfer, Case No. 21-0971GC will be re-designated to be fully formed.

*Finally, in issuing this determination, the Board is mindful of the Covid-19 pandemic. Notwithstanding, be advised that **this filing deadline is firm** as the Board has determined to specifically exempt it from Board Alert 19's suspension of Board filing deadlines.*

Board Members:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Gregory H. Ziegler, CPA
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/19/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

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

[6] See 3.3.2.1 of External User Manual located at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/OH-CDMS-PRRB-External-User-Manual-v-10.pdf.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Determination on Expansion of CIRP Group to Meet Amount In Controversy Threshold***

HRS DCH 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group, Case No. 17-1742GC[1]

DCH 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group, Case No. 21-0974GC

DCH Regional Medical Center (01-0092) FYE 9/30/2011, Case No. 20-1606

Dear Mr. Ravindran and Ms. Huggins:

On March 28, 2022, the Provider Reimbursement Review Board (the "Board") issued a Request for Information ("RFI") requesting the Parties' comments regarding an earlier proposal to consolidate the subject calendar year ("CY") 2014 common issue related party ("CIRP") group, Case No. 17-1742GC, into a reopened and expanded CY 2015 Dual Eligible Days CIRP group, Case No. 21-0974GC.[2] The consolidation was proposed in order to resolve the issue that Case No. 17-1742GC failed to meet the $50,000 amount in controversy threshold. Because the two groups involved different Group Representatives, the Board also required an updated authorization letter, designating the Representative for the surviving group.

On April 8, 2022, Quality Reimbursement Services, Inc. ("QRS") was appointed as the Group Representative for Case No. 17-1742GC, replacing HRS. On April 11, 2022, QRS filed its response to the Board's RFI, in which it concurred with the Board's proposal to expand the later year CIRP group under Case No. 21-0974GC. On the same date, QRS rescinded its April 11, 2022 RFI response and resubmitted a revised response the following day. In its April 12, 2022 correspondence, QRS not only agreed with the Board's proposal to reopen the status of Case No. 21-0974GC in order to expand and consolidate the CY 2014 CIRP group Case No. 17-

[1] The group name includes the abbreviation of the representative that filed the group, Hospital Reimbursement Services, Inc. ("HRS").
[2] Case No. 21-0974GC was designated to be fully formed on March 4, 2022 in the Office of Hearings Case & Document Management System ("OH CDMS").

1742GC, it also requested that an additional CY be included in the group. According to QRS there is an additional provider, DCH Regional Medical Center (01-0092), for CY 2011 that is appealing the Medicaid Fraction Dual Eligible Days issue in an individual appeal under Case No. 20-1606.[3] Therefore, QRS proposed that the Board expand the CY 2015 CIRP group under Case No. 21-0974GC to include CY 2011, as well as CY 2014. QRS certified that there are no relevant factual or regulatory changes for the DSH Medicaid Fraction Dual Eligible Days issue between CYs 2011 through 2015.

Board Determination:

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

Board Rule 12.5 indicates that "[p]roviders in a group appeal must have final determinations for their cost reporting periods that end with the same calendar year. However, groups may submit a written request to include more than one calendar year to meet the minimum number of providers . . . ".[4] In addition, "[o]ne or more of the providers bringing a group appeal . . . **subject to the Board's discretion**, may appeal more than one cost reporting period with respect to the issue that is the subject of the group appeal for other purposes. . . ".[5] (emphasis added) With regard to the number of Providers in a fully formed CIRP group, 42 C.F.R. § 405.1837(b)(1) and Board Rule 12.6.1 provide that a single provider under common ownership or control may initiate a Common Issue Related Party ("CIRP") group, **but require that at least two different providers be in the group upon full formation**.

After a review of the CYs 2014 and 2015 Medicaid Fraction Dual Eligible Days CIRP groups, the Board agrees to reopen the status of Case No. 21-0974GC in order to consolidate the two years in order to meet the $50,000 group threshold. Additionally, the Board agrees to allow Case No. 21-0974GC to be further expanded to include CY 2011. The group name is being modified to "DCH CYs 2011 & 2014 - 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group."

With the consolidation of Case No. 17-1742GC into Case No. 21-0974GC there are no remaining participants in the CY 2014 CIRP group. Therefore, Case No. 17-1742GC is hereby closed and removed from the Board's docket.

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[3] Case No. 20-1606 was created by the Board on May 4, 2020 when it was determined that DCH Regional Medical Center was the sole participant in the DCH Health CY 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group under Case No. 19-1799GC. Prior to the Board agreeing to the creation of the individual appeal, QRS certified that there were no other DCH providers pursuing the issue for CY 2011. Case No. 20-1606 also includes three additional issues from other single participant groups that were also disbanded.
[4] Board Rules (Aug. 29, 2018; revised Nov. 1, 2021)
[5] 42 C.F.R. § 405.1837(b)(ii).

Because Case No. 20-1606 is fully populated in OH CDMS, QRS is advised that, within 15 days of the signature date of this notification, it must effectuate the transfer of the Medicaid Fraction Dual Eligible Days issue from the individual appeal to Case No. 21-0974GC by using the "Transfer" button in OH CDMS.[6] Upon completion of the transfer, Case No. 21-0974GC will be re-designated to be fully formed.

Finally, in issuing this determination, the Board is mindful of the Covid-19 pandemic. Notwithstanding, be advised that ***this filing deadline is firm*** *as the Board has determined to specifically exempt it from Board Alert 19's suspension of Board filing deadlines.*

Board Members:
Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Gregory H. Ziegler, CPA
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/20/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

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

[6] See 3.3.2.1 of External User Manual located at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/OH-CDMS-PRRB-External-User-Manual-v-10.pdf.

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Via Electronic Delivery

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Ropes & Gray
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RE: **Duplicative Issue in Multiple Appeals**
Case No. 22-0048 – Sentara Williamsburg Reg'l Med. Ctr. (Prov. No. 49-0066, FYE 12/31/2017)
Case No. 22-0047GC – Sentara Healthcare CY 2017 Bad Debt CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the above captioned appeals in connection with a potential prohibited duplicative issue in the individual appeal. Set forth below is the Board's ruling.

Background:

The above-captioned appeals were filed with the Board using the Office of Hearings Case and Document Management System ("OH CDMS") on October 19, 2021. The subject individual appeal is based on the Notice of Program Reimbursement ("NPR") dated April 22, 2021 for the Provider's fiscal year end ("FYE") 12/31/2017. The appeal consists of a ***sole** issue*: Disallowance of Bad Debt for Indigent Patients.

The subject Common Issue Related Party ("CIRP") group appeal is identified as the Sentara Healthcare CY 2017 Bad Debt CIRP Group. It is noted that, at the time of the CIRP group's filing, the subject Provider, Sentara Williamsburg Regional Center (Prov. No. 49-0066), was directly added to the CIRP group based on the same NPR.

Request for Information:

Board Rule 4.6.1 states that a "provider may not appeal and pursue the same issue from a single final determination in more than one appeal (individual or group)." Board Rule 12.3.1 states "Providers under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. *See* 42 C.F.R. § 405.1837(b)."

By letter dated March 10, 2022, the Board requested clarification from the Provider to explain why the bad debt indigence issue in the individual appeal is not duplicative of the bad debt indigence issue in the CIRP group.

In its reply dated April 11, 2022, the Provider advised that the Board correctly noted that both the individual and group appeal "involve the adequacy of documentation for bad debt indigence determinations." The Provider advised that it had initially understood that the MAC's disallowances raised distinct issues that could entail different decisions from the Board and, thus, appealed certain accounts to the group appeal and certain different accounts to the individual appeal. The Provider further advised that, after further review of the detailed workpapers, the Provider agrees that the issues are overlapping, as in the case recently decided for this and other Sentara hospitals for prior cost reporting periods. *See Sentara Hosps. v. Azar*, No. 20-CV-3771 (CRC), 2022 WL 910514, at *5- 8 (D.D.C. Mar. 29, 2022). The Provider, therefore, requested that the Board consolidate (or transfer) the Provider's individual appeal into the group appeal.

As noted in the Board's previous correspondence, the subject Provider, Sentara Williamsburg Regional Medical Center, Provider No.: 49-0066, is ***already*** a participant in the CIRP group, Case No. 22-0047GC, as it was directly added to the CIRP group when the group was initially filed on October 19, 2021 based on the ***same*** NPR. In this regard, the Board notes that the group issue must be common to all providers participating in the group and, thus, the group issue statement governs the scope of the group appeal

Since the sole issue in Case No. 22-0048, the Disallowance of Bad Debt for Indigent Patients, is now being pursued in the CIRP group under Case No. 22-0047GC, there are no further issues for the Board to adjudicate in the subject individual appeal. Therefore, the Board hereby dismisses and closes Case No. 22-0048.

Board Members:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

4/20/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdiction/EJR Determination***
QRS Empire Health 2008 SSI – Dual Eligible Days Group
Case No. 15-3123GC

Dear Mr. Ravindran:

In reaching the Jurisdiction/EJR determination in this correspondence, the Provider Reimbursement Review Board ("Board") has reviewed: (a) Empire Health's March 13, 2020 request for expedited judicial review ("EJR") for the above-captioned common issue related party ("CIRP") group; (b) Empire Health's December 24, 2020 response to the Board's November 30, 2020 request for information; (c) the December 30, 2020 submission of an unsigned settlement agreement; and (d) Empire Health's January 28, 2021 response to the Board's January 21, 2021 request for information, all of which are related to Empire Health's request for EJR. In addition, the Board has considered the Medicare Contractor's December 1, 2020 comments indicating that it believed the consolidation of Case Nos. 15-3123GC and 17-0554GC was appropriate.

Effect of COVID -19 on Board Operations

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

Although the Schedule of Providers was delivered to the CMS 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 mandatory telework. Consequently, the Board did not have access to its office to locate the Schedule of Providers submitted on March 3, 2020. Further, the Board has not resumed normal operations, but is attempting to process EJR requests as expeditiously as possible 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 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 [Medicare Contractor], or should be excluded Medicare fraction of the DSH adjustment, and instead be included in the Medicare fraction [of the DSH adjustment]. . . .[1]

Background

On November 30, 2020, in response to Empire Health's March 13, 2020 EJR request, the Board notified the parties that "[t]he Schedule of Providers for Case No. 14-3123GC ***improperly*** listed #1 Deaconess Medical Center (Prov. No. 50-0044, FYE 9/20/2008)"[2] ("Deaconess"). The Board explained that Deaconess was one of two Providers in the CIRP group.[3] The supporting documentation for Deaconess revealed that, on November 12, 2012, it had filed an appeal from a Notice of Program Reimbursement ("NPR") issued on June 29, 2012 for the sole issue of cross-over bad debts. This individual appeal was assigned Case No. 13-0041. On February 8, 2013, Deaconess added a number of issues to the individual appeal, including the dual eligible days issue. On August 15, 2015 Quality Reimbursement Services ("QRS") requested the transfer of the dual eligible days issue from Case No. 13-0041 to Case No. 15-3123GC.

Subsequently, on February 23, 2016, the Board issued a jurisdictional determination in case number 13-0041 in which it concluded that:

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[1] Providers' EJR request at 2-3 (emphasis added).
[2] (Emphasis added.)
[3] The second provider in Case No. 15-3123GC was Valley Hospital Medical Center (Prov. No. 50-0119, FYE 9/30/2008).

1. The Board lacked jurisdiction over the bad debt issue that was used to establish the individual appeal;
2. There was no valid appeal to which the issues that were subsequently added to the appeal, one of which was the dual eligible days issue, could be attached; and
3. The added issues (again, one of which was the dual eligible days issue) were added more than 180 days after the issuance of the NPR (as required by 42 C.F.R. § 405.1835(a) for Board jurisdiction) and, therefore, failed to meet the 180-day requirement of a stand-alone appeal.

Accordingly, the Board dismissed the bad debt issue as well as the issues that were added to the appeal, including the dual eligible days issue. As a result of this dismissal of the individual case in its entirety, the Board voided the prior transfers,[4] including the transfer of the dual eligible days to Case No. 15-3123GC. The Board then closed Case No. 13-0041 and removed it from the Board's docket.

On March 14, 2016, Deaconess requested reconsideration of the Board's dismissal. On June 17, 2016, the Board denied the request for reconsideration and reaffirmed its dismissal, including the dismissal of the added issues (again, including the dual eligible days issue).

Roughly 4 years later, on March 3, 2020, QRS submitted a Schedule of Providers ("SoP") with supporting jurisdictional documentation. The Board notes that Board Rules specify that the supporting jurisdictional documentation must demonstrate that the Board has jurisdiction over each of the providers named in the group appeal.[5] Significantly, the SoP included Deaconess; however, the supporting documentation failed to include any documentation related to the Board's 2016 dismissal and related voiding of transfers (or copies of the Administrator's Remand Order and the Settlement Agreement). Rather, QRS *only* included documents related to the initial appeal request to establish Case No. 13-0041 and transfer request to Case No. 13-3123GC.

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[4] Deaconess transferred the following issues to group appeals:
1. Outlier Payments was transferred to Case No. 13-2364GC (case closed 1/5/16 through withdrawal of the case)
2. DSH/SSI Dual Eligible Days issue was transferred to Case No. 15-3123GC (the subject of this letter);
3. DSH/SSI Systemic Errors was transferred to Case No. 15-3126GC (closed 4/8/16 following the Board's grant of EJR in the case);
4. DSH/SSI Managed Care Days issue was transferred to Case No. 15-3484GC (closed 4/12/19 following the Board's grant of EJR in this case).

[5] *See* 42 C.F.R. § 405.1837(e)(2) (stating: "The Board may make jurisdictional findings under § 405.1840 at any time, including, but not limited to, following a request by the providers for the jurisdictional findings. The providers may request jurisdictional findings by notifying the Board in writing that the group appeal is fully formed, or that the providers believe they have satisfied all of the requirements for a group appeal hearing request, and the Board may proceed to make jurisdictional findings. The providers must include with the notice any additional information or documentary evidence that is required for group appeal hearing requests."); Board Rule 20 (2018) (stating for example in Rule 20.1 that "the group representative must prepare a schedule of providers (Model Form G at Appendix G) and supporting jurisdictional documentation that demonstrates that the Board has jurisdiction over the providers named in the group appeal (see Rule 21)."); Board Rule 21 (2018) (stating "The schedule of providers must include all providers in the group and provide the associated documentation to support jurisdiction of the participating providers.).

Accordingly, in its November 30, 2020 jurisdictional decision, the Board notified the parties that, as a result of the Board's prior 2016 jurisdictional determination in Case No. 13-0041 (and associated dismissal of the dual eligible days issue), the transfer of Deaconess to Case No. 15-3123GC was void. Consequently, the Board removed Deaconess from Case No. 15-3123GC. A second Provider, Valley Medical Center (Prov. No. 50-0119, FYE 9/30/2008), remains in Case No. 15-3123GC. However, a group consisting of a single provider does not comply with the requirements of 42 C.F.R. § 405.1836(b)(1) which requires a completed group to consist of, at least, two providers. As a result, the Board notified the parties that it was proposing to transfer Valley Medical Center to Case No. 15-0554GC, QRS Empire Health 2005 SSI[6] Dual Eligible Days Group as required by Board Rule 18.[7] The parties had 30 days to file comments (*i.e.*, by December 30, 2020).

On December 24, 2020, QRS timely responded to the Board's request for comments. In that letter, QRS stated that it believed Deaconess should remain in Case No. 15-3123GC because the Secretary vacated the Board's February 23, 2016 jurisdictional decision in Case No. 13-0041 in a settlement agreement for Case No. 13-0041 which required the Board to take jurisdiction over Deaconess. However, QRS did ***not*** include a copy of that agreement with its filing. Notwithstanding, several days later on December 30, 2020, QRS submitted an unsigned,[8] unfiled/unstamped[9] copy of the settlement agreement (still in redline[10]) in litigation captioned *Empire Health Foundation for Deaconess Medical Center v. Price,* Case No. 2:16-cv-135, before the U.S. District Court for the Eastern District of Washington.

On January 21, 2021, the Board sent the parties another letter noting the deficiencies in the alleged settlement agreement document as well as the following:

> (1) the Board closed Deaconess' individual case under Case No. 13-0041 on February 23, 2016 following the dismissal of the original bad debt issue and all subsequently "added" issues; and (2) in instances such as this where a Board dismissal is appealed to federal court, either an Administrator's Remand Order or a request for reinstatement must be filed in order for the Board to take any further action on a dismissed case. Here, there is no record of a Remand Order issued by the Administrator in Case No. 13-0041 with instructions to the Board to reinstate the case or specific issues. Similarly, the Board has no record of a pending request for reinstatement of that case. In this regard, the Board notes that the

[6] Supplemental Security Income.
[7] The Board Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview.
[8] The signature lines for the AUSA and OGC for HHS had an "s" on it was not dated and there was no means to authenticate that "s." Moreover, the Provider had not signed this copy of the settlement agreement.
[9] The document was not stamped as having been filed with the U.S. District Court.
[10] The first page of the alleged settlement agreement contained changes in redline in the third "WHEREAS" clause.

> regulation, 42 C.F.R. § 405.1885(b)(2)(i), permits a decision to reopen if the request to reopen is made within 3 years of the issuance of the decision. The Board Rule 47 governs reinstatements and impose a similar three year requirement. Here, the Board cannot reopen its dismissal decision in Case No. 13-0041 or otherwise reinstate Case No. 13- 0041 because the case has been closed for well more than three years (close to 5 years since the February 23, 2016 dismissal). Thus, to the extent the QRS' December 24, 2020 letter is a request for reinstatement and/or reopening of the Board's February 23, 2016 dismissal decision, then the Board hereby denies it as the time for reinstatement and/or reopening has tolled.[11]

Based on the above findings, the Board denied reinstatement/reopening of Case No. 13-0041 because the 3-year period allowed under 42 C.F.R. § 405.1885(b)(1) and Board Rule 47.1 for reinstatement or reopening had tolled and the Board had not received an Administrator Remand Order, either vacating or directing other action on the Board's February 23, 2016 decision. As a consequence, the Board found that Case No. 15-3123GC was fully formed with one participant Valley Hospital Medical Center (Prov. No. 50-0044, FYE 9/30/2008) and notified the parties that, under separate cover, the Board would be transferring Valley Hospital Medical Center into Case No. 17-0554GC consistent with its Rule 18 Notice issued on November 30, 2020.

On January 28, 2021, QRS responded to the Board's concerns about the authenticity of the settlement agreement in Case No. 13-0041 by submitting a copy of a letter dated June 5, 2019 sent to Teresa Sherman, Esq., of the law firm Paukert & Troppmann, transmitting the Administrator's Remand Order and the signed settlement agreement in Case No. 13-0041. QRS asserts that the Board must take jurisdiction over Deaconess with regard to the crossover bad debt and SSI percentage issues and again requested reinstatement of Case No. 13-0041. Further, QRS asserted that Deaconess should have been transferred into Case No. 15-3123GC. As a separate matter, QRS made the following curious statement regarding the Board's November 30, 2020 letter:

> On page 2 of the Board's letter dated November 30, 2020 . . . the Board addressed the transfer of a Dual Eligible days issue from [Case No.] 13-0041 to [Case No.] 15-3126GC. Case number 15-3126 has gone to court had been decided in favor of the Provider in the Ninth Circuit Court of Appeals. When 15-3126GC is remanded to the PRRB, we ask that Deaconess Medical Center be included in the list of provider included in case 15-3126GC for settlement purposes.

[11] (Footnotes omitted.)

The Board's reference to 15-3126GC in its November 30, 2020 letter was a typographical error and was instead a reference to 15-3123GC.[12]

That said, it is significant that, in the above quote, QRS admits that Empire Health has already pursued the Medicaid dual eligible as part of another CIRP group under Case No. 15-3126GC and that, at that time, the Ninth Circuit Court of Appeals had ruled in favor of Empire Health. This raises potential prohibited duplicate filings or appeals as stated in Board Rule 4.6 (2018) and in this regard Board Rule 4.6.1 prohibits appealing an issue from a single determination in more than one appeal.[13] QRS failed to address the prohibited duplicate appeal issue.

Moreover, The Board notes that the documentation attached to the Provider's letter dated January 28, 2021 confirms that the District Court accepted the parties' Stipulation for Voluntary Dismissal With Prejudice and then *dismissed the case* ***with prejudice*** (as opposed to remanding the case for action consistent with his order). The Administrator implemented the Settlement Agreement and remanded the matter to the Board consistent with 42 C.F.R. § 405.1877. In the regard, the Board notes that § 405.1877(g)(1) states, in pertinent part:

> If a court, in a civil action brought by a provider against the Secretary as the real party in interest regarding a matter pertaining to Medicare payment to the provider, orders a remand for further action by the Secretary, any component of HHS or CMS, or the contractor, *the remand order* ***must be deemed***, except as provided in paragraph (g)(3) of this section, *to be directed to the Administrator in the first instance*, regardless of whether the court's remand order refers to the Secretary, the Administrator, the Board, any other component of HHS or CMS, or the contractor.

Thus, while the settlement agreement specifies that the Board must take certain actions, per the 42 C.F.R. § 405.1877(g)(1), those directives ***must be deemed*** to be directed to the CMS Administrator in the first instance.[14]

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[12] It is clear the refence of the transfer of the Medical days issue from Case No. 13-0041 to Case No 15-3126GC was a typo and should have been stated as a transfer to Case No. 15-3123GC for several different reasons: (1) the letter references that same transfer on the top of page 3 and correctly describes it as a transfer to Case No. 15-3123GC ("Accordingly, the Board dismissed the bad debt issue and the issues that were added to the appeal, including the dual eligible days issue. As a result of this dismissal, the prior transfers, including the transfer of the dual eligible days to Case No. 15-3123GC, were voided."); (2) Case No. 14-3123GC is entitled "QRS Empire Health 2008 SSI – Dual Eligible Days CIRP Group"; (3) the typo appears in the opening paragraph of Section B discussing the Schedule of Providers for Case No. 15-3123GC; (4) the first sentence of the paragraph references Case No. 15-3123GC; and (5) while Case No. 15-3123GC is mentioned throughout the 5-page letter, Case No. 15-3126GC appears only once and it was clearly a typo.

[13] *See also* Board Rule 4.5 (2009, 2013, 2015).

[14] The Board notes that 42 U.S.C. § 1395oo(f)(1) states: "A decision of the Board shall be final unless the Secretary, on his own motion, and within 60 days after the provider of services is notified of the Board's decision, reverses, affirms, or modifies the Board's decision. Providers shall have the right to obtain judicial review of any final decision of the Board, or of any reversal, affirmance, or modification by the Secretary, by a civil action commenced

Subsequent to the receipt of QRS' January 28, 2021 letter requesting reinstatement of Case No. 13-0041 and the transfer of Deaconess from Case No. 13-0044 to both Case Nos. 15-3123GC and 15-3126GC, the Board reviewed the available record in Case Nos. 15-3123GC and 15-3126GC. It should be noted that in both Case No. 15-3126GC, the QRS Empire Health 2008 SSI Percentage Group ("SSI Percentage Group"), and Case No. 15-3123GC, the QRS Empire Health 2008 SSI-Dual Eligible Days Group ("Dual Eligible Days Group), the Board had previously denied in the transfer of Deaconess from Case No. 13-0041 into those group appeals as part of the February 23, 2016 jurisdictional determination in Case No. 13-0041.

A. Case No. 15-3126GC DSH SSI Percentage Group

On August 3, 2015, QRS established the CIRP group under Case No. 13-3126GC entitled "QRS Empire Health 2008 SSI Percentage CIRP Group – NPR Based." On August 6, 2015, QRS certified that the group was complete.

On February 8, 2016, QRS filed an EJR request for this case and requested the Board to consider EJR for the issue of:

> Whether the Secretary properly calculated the Providers' [DSH]/Supplement Security Income percentage.

The Providers' EJR request stated that they were challenging the validity of CMS' regulation, 42 C.F.R. § 412.106(b)(2), specifically the application of "entitled" in the denominator of the SSI fraction for purposes of the DSH calculation. The Providers explained that, effective on October 1, 2004, CMS amended section 412.106 to change the previous regulation from "Determine the number of *covered* patient days" to "Determine the number of patient days."[15] As a result of this change, the Secretary considers an individual be "entitled to benefits under part A" regardless of whether the days were covered or paid by Medicare, they will be included in the denominator of the SSI fraction.

On April 8, 2016, the Board granted EJR in Case No. 15-3126GC. As part of that EJR determination, the Board noted that, on February 23, 2016, the Board voided the transfer of Deaconess from Case No. 13-0041 to Case No. 15-3126.[16] Specifically, in its jurisdictional determination in Case No. 13-0041, the Board concluded that it lacked jurisdiction over the original issue appealed in Case No. 13-0041, crossover bad debts. Since there was no jurisdictionally valid appeal to which the DSH SSI issue could be added, the Board dismissed the SSI issue from Case No. 13-0041 and voided the transfer to Case No. 15-3126GC. Accordingly, the Board granted EJR in Case No. 15-3126GC only for the remaining participant, Valley Hospital Medical Center (Prov. No. 50-0119, FYE 9/30/08).

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within 60 days of the date on which notice of any final decision by the Board or of any reversal, affirmance, or modification by the Secretary is received." *See also* 42 C.F.R. § 405.1877.

[15] The proposed change to the regulation was published in the August 11, 2004 Federal Register (69 Fed. Reg. 48916, 49098).

[16] *See infra note* 25 and accompany text.

The Board understands that this case proceeded through U.S. District Court for the Eastern District of Washington and the U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") now styled as *Empire Health Found. v. Azar* ("*Empire*"). The Ninth Circuit reviewed the Washington District Court's decision in *Empire*[17] 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.[18] 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."[19] However, the Ninth Circuit then reviewed the 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*")[20] 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."[21] 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."[22] Accordingly, 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."[23] Accordingly, the Ninth Circuit took 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[24]

[17] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[18] *Id.* at 884.
[19] *Id.* at 884.
[20] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[21] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[22] *Id.* at 886.
[23] *Id.*
[24] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

B. Case No.13-3123GC QRS Empire Health SSI-Dual Eligible Days Group

On August 3, 2015, QRS established the CIRP group under Case No. 13-3123GC entitled "QRS Empire Health 2008 SSI – Dual Eligible Days CIRP Group." On August 6, 2015, QRS certified that the group was complete with 2 participants, including Deaconess based on a transfer from Case No. 13-0041. On February 23, 2016, the Board dismissed Case No. 13-0041 in its entirety and voided the transfer of Deaconess' dual eligible days issue to Case No. 13-3123GC.[25] As a result, as of February 23, 2016, Deaconess was no longer a participant in Case No. 13-3123GC.

On February 27, 2020, QRS filed another copy of the Schedule of Providers and again certified that the group was complete. However, the Schedule of Providers still listed Deaconess as a participant and had not been updated to reflect the Board's 2016 dismissal of Deaconess. Indeed, none of the attached supporting jurisdictional documentation included any recognition of the Board's 2016 dismissal (much less, as the Board now knows, of the Provider's appeal of the 2016 dismissal to the U.S. District Court for the Eastern District of Washington and the executed settlement agreement filed for that case).

On March 13, 2020, QRS filed an EJR request for this case and identified the issue for which EJR had been requested as:

> Whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "dual eligibles"), and for whom Medicare has not made payment for that inpatient stay . . . should be included in the Medicare fraction of the Medicare [DSH] adjustment as alleged by the MAC [Medicare Administrative Contractor], or should be excluded from the Medicare fraction of the DSH adjustment, and instead be included in the Medicaid fraction, as alleged by the [P]roviders.[26]

The Providers contend that non-covered patient days should be included in the denominator of the Medicaid fraction, and that, where a patient is eligible for Medicaid, noncovered days belonging to that patient should be included in the numerator of the Medicaid fraction.[27] The Providers note that, in the August 11, 2004 Final Inpatient Prospective Payment System Rule ("IPPS"),[28] effective for patient discharges on or after October 1, 2004, the Secretary deleted the word "covered" where it previously appeared in the definition of the Medicare fraction in 42 C.F.R. § 412.106(b)(2)(i). The deletion of the term "covered" reflected the Secretary's intent to begin including days not actually paid under Medicare Part A in the Medicare fraction. Thus,

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[25] The transfer was voided because Case No 13-0041 was established based on an appeal for only ***one*** issue (crossover bad debts) and, when the Board dismissed that founding issue, it necessarily had to dismiss all of the other issues that had been added to the appeal became void (including but not limited to the dual eligible days issue) since there was no longer a valid appeal to which issue could be added.
[26] Providers' March 13, 2020 EJR request at 2-3.
[27] *Id.* at 1.
[28] 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004).

both exhausted benefit and Medicare secondary payor days associated with patient discharges on or after October 1, 2004 were included in the Medicare fraction.

Decision of the Board

The Board hereby dismisses the appeal of Case No. 15-3123GC, QRS Empire Health SSI-Dual Eligible Days Group, and denies the Provider's request for EJR because the Board has already issued an EJR determination with respect to the dual eligible days issue in Case No. 15-3126GC for the fiscal year 2008, *more than* ***six (6) years ago*** on April 8, 2016. Specifically, the Provider is challenging the ***same*** regulatory change made in 2004 as part of the FY 2005 IPPS Final Rule and is asking for the ***same*** relief. Board Rule 4.6.1[29] precludes appeal of the ***same*** issue for the ***same*** year in multiple cases. The rule states that "[a] provider may not appeal an issue from a single determination in more than one appeal."

Further, Empire Health is subject to the CIRP group regulations and the regulations prevent multiple CIRP group appeals for the ***same*** issue and the ***same*** year. The regulation, 42 C.F.R. § 405.1837(b)(1)(i) mandates the use of group appeals where:

> (i) Two or more providers under common ownership or control that wish to appeal to the Board *a specific matter at issue that involves* ***a*** *question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year*, and for which the amount in controversy is $50,000 or more in the aggregate, *must bring the appeal as a group appeal.*[30]

Further, § 405.1837(f)(2) confirms that "[t]he Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal." Finally, § 405.1837(e)(1) confirms that, once a CIRP group is fully formed for a particular issue and year, no other provider under the same common ownership or control may pursue that issue for that year:

> 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.*[31]

[29] The Board Rules are found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview.
[30] (emphasis added)
[31] *Id.*

Accordingly, 6 years ago when the Board granted EJR over the dual eligible days issue challenging the validity of the regulatory change made in the FY 2005 IPPS Final Rule, it foreclosed Empire Health from pursuing that ***same*** issue outside of that CIRP for that year (regardless of whether it is part of an individual appeal or another group, optional or CIRP).

Moreover, the Board notes that it cannot reopen its April 8, 2016 EJR determination. Both 42 C.F.R. § 405.1885(b)(1) and Board Rule 47.1 limit the time for submitting a request to reopen a final determination to 3 years and that 3 years expired on Monday, April 8, 2019. In particular, the regulation, 42 C.F.R. § 405.1885(b) states, in relevant part:

> (b) Time limits—
>
> ******
>
> (2) Request for reopening of a determination not based on fraud or similar fault.
>
> (i) A reopening made upon request is timely only if the request to reopen is received by CMS, the contractor, or reviewing entity, as appropriate, *no later than **3 years** after the date of the determination or decision* that is the subject of the requested reopening. The date of receipt by CMS, the contractor, or the reviewing entity of the request to reopen is determined by applying the date of receipt presumption criteria for reviewing entities defined in § 405.1801(a), unless it is shown by clear and convincing evidence that CMS, the contractor, or the reviewing entity received the request on an earlier date.

Indeed, the Administrator's *remand of Case No. 13-0041* purportedly[32] occurred on or about June 5, 2019 but this was roughly 2 months after the tolling of the 3-year reopening time frame for Case No. 15-3126GC.[33] The Board is addressing, under separate cover, the Administrator's remand of Case No. 13-0041 in a determination being issued concurrently in Case No. 13-0041.

---

[32] The Administrator sent the Administrator's Order to the Provider's counsel Case No. 13-0041 via letter dated June 6, 2021 and the Board is listed as a carbon copy. However, the Board has no record of having received the Administrator's Order *from the Administrator* until February 11, 2021. The first record of the Board receiving a copy of the Administrator's Order appears to be in January 2021 when the Group Representative in the Empire Health common issue related party ("CIRP") group under Case No. 15 3123GC sent the Board a copy (but only after the Board had removed Deaconess from the Schedule of Providers for Case No. 15-3123GC and issued two separate requests for information relating to Deaconess). The Board further notes that: (1) it had a building emergency in September 2019 requiring it to vacate its facilities and requiring all of its files to go through fire remediation (*see* Board Alert 18); and (2) subsequently, in March 2020, CMS announced that the Agency, including the Board, was in maximum telework status and, as a result, the Board issued temporary changes to is procedures, including notifying interested parties that it was not in the office to receive any hard copy filings (*see* Board Alert 19).

[33] The Board notes that the Settlement Agreement was executed by Empire Health on March 1, 2018 well in advance of the 3 year tolling date and that Paragraph 12 of the Settlement Agreement states: "If a party to this lawsuit questions another party's compliance with this Agreement, then the parties must make a serious effort to resolve any

*****

In summary, as Case No. 15-3123GC is a prohibited duplication of Case No. 15-3126GC in which the Board issued an EJR determination for Empire Health with respect to the ***same*** dual eligible days issue for the ***same*** year, the Board hereby dismisses Case No. 15-3123GC (the QRS Empire Health SSI-Dual Eligible Days Group) and, accordingly, denies the Empire Health's request for EJR of the CIRP group under Case No. 15-3126GC. The Board hereby closes Case No. 15-3132GC and removes it from the Board's docket.

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

Board Members Participating

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Kevin D. Smith, CPA

FOR THE BOARD:

4/21/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
Signed by: PIV

cc: Byron Lamprecht, WPS
Wilson Leong, FSS

such questions on their own. But if the parties are not able to resolve such questions on their own, they must ask the Secretary's agency counsel (identified below) whether CMS will render an opinion on the matters in question."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Wilkes Regional Medical Center (Provider No. 34-0064)
FYE 9/30/2013
Case No. 16-2521

Dear Mr. Ravindran,

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

Pertinent Facts:

Wilkes Regional Medical Center submitted a request for hearing on September 23, 2016 from a Notice of Program Reimbursement ("NPR") dated March 29, 2016. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Part C Days – SSI Fraction
- Issue 4: DSH Dual Eligible Days Exhausted Part A – SSI Fraction
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days Exhausted Part A – Medicaid Fraction
- Issue 8: Outlier Payments – Fixed Loss Threshold

On May 22, 2017, the Provider transferred Issues 2, 3, 4, 6, 7, and 8 to group appeals. Issue 2, DSH SSI Percentage (Systemic Errors), was transferred to PRRB Case No. 17-1511GC – QRS Carolinas HealthCare System 2013 SSI Systemic CIRP. After these transfers, Issues 1 and 5 are the sole remaining issues.

The Medicare Contractor submitted a jurisdictional challenge on Issue 1 on March 7, 2022.[1] The Provider did not submit a responsive brief.

In its appeal request, the Provider summarizes Issue 1, the DSH SSI Percentage (Provider Specific) issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[2]

Similarly, the Provider describes Issue 2, the DSH SSI Percentage (Systemic Errors) issue, which has been transferred to Case Number 17-1511GC, as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider further contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] The jurisdictional challenge superseded a jurisdictional challenge that was submitted on April 27, 2018.
[2] Individual Appeal Request, Issue 1 Issue Statement.

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

The Provider submitted its Final Position Paper on February 10, 2022. It did not address Issue 2 in its Final Position Paper.

Medicare Contractor's Contentions

The Medicare Contractor contends Issue 1 should be dismissed from this case. According to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. As noted above, the Provider transferred Issue 2 to Group Case No. 17-1511GC, "*QRS Carolinas HealthCare System 2013 SSI Systemic CIRP*." The Medicare Contractor contends that the portion of Issue 1 related to SSI data accuracy should be dismissed because it is duplicative of the issue under appeal in Group Case No. 17-1511GC.[4]

The Medicare Contractor also contends that the portion of Issue 1 related to SSI realignment should also be dismissed. The Medicare Contractor contends that the Provider's appeal over SSI realignment has been abandoned or withdrawn in accordance with Board Rule 25.3. The Medicare Contractor also notes that the Provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the Provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end. Thus, realignment of the SSI would have no effect. Alternatively, the Medicare Contractor asks the Board to dismiss this issue as premature consistent with other recent jurisdictional decisions.[5]

Board Decision:

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

The Board finds that it does not have jurisdiction over Issue 1, the DSH SSI Percentage (Provider Specific) issue. This jurisdictional analysis of Issue 1 has two components:

[3] Individual Appeal Request, Issue 2 Issue Statement.
[4] Medicare Contractor's jurisdictional challenge at 7.
[5] *Id.*

1. The Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and

2. The Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The Board finds that the first aspect of Issue 1- the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage - is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 17-1511GC, "*QRS Carolinas Healthcare System 2013 SSI Systemic CIRP*. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8] Issue 2, transferred to group Case No. 17-1511GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 transferred to Case No. 17-1511GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Jul. 1, 2015), the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 17-1511GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[9] Provider is incorrect in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide any evidence)

---

[6] Individual Appeal Request, Issue 1.
[7] Individual Appeal Request, Issue 1.
[8] Individual Appeal Request, Issue 1.
[9] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 17-1511GC. To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[10] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 by explaining the nature of any alleged "errors" in its Final Position Paper and including *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[11] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its Final Position Paper on February 10, 2022, in direct violation of Board Rule 25.2.2:

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

Accordingly, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case No. 17-1511GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. In the alternative, the Board dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the Provider abandoned the SSI realignment portion of Issue 1 as it did not brief the issue in its final position paper.

Board Rule 27 addresses final position papers. Specifically, the content of final position papers is addressed at 27.2:

> The final position paper should address **each issue remaining in the appeal**. The *minimum* requirements for the position paper narrative

[10] (Emphasis added.)
[11] (Emphasis added.)

> and exhibits are the same as those outlined for preliminary position papers at Rule 25.[12]

Board Rule 25.3 Filing Requirements to Board states the following:

> If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issued abandoned and effectively withdrawn.

As the Provider abandoned the SSI realignment portion of Issue 1 in its final position paper, the Board dismisses the SSI realignment portion of Issue 1 from the appeal.

The Board also notes that the Provider's fiscal year end is September 30, which is the same as the federal fiscal year. As such, realignment would have no effect, as the underlying data would not change, and the months included would not change.

Conclusion:

The Board dismisses Issue 1, the DSH SSI Percentage (Provider Specific) issue, in its entirety from this appeal. The case remains open given that another issue, Issue 5, DSH Medicaid Eligible Days, remains pending.

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

Board Members Participating:

Clayton J. Nix, Esq.
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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/26/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, Federal Specialized Services

[12] (Emphasis added.)

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Deborah Mayland-Poyzer
Fairview Health Services
400 Stinson Boulevard NE
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RE: **Jurisdictional Determination**
Fairview Health Services 2008 Medicaid Fraction for Medicare HMO Days CIRP Group, PRRB Case No. 13-0939GC

Specifically, Fairview Ridges Hospital (Prov. No.: 24-0207) and Fairview Northland Regional Medical Center (Prov. No. 24-0141) as participants

Dear Ms. VanArsdale and Ms. Mayland-Poyzer:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's ("MAC") Jurisdictional Challenge over the two initiating Providers that were directly added to the group from receipt of their original Notices of Program Reimbursement ("NPRs"). The Board's decision is set forth below.

Background:

On March 4, 2013 Fairview Health Services filed a request for a group appeal for the Medicaid Fraction for Medicare HMO Days issue for the fiscal years end (FYE's) 2006 through 2008. The Board acknowledged Fairview's request by establishing separate group appeals for each of the three FYEs. The FYE 2008 group was assigned Case No. 13-0939GC and was formed with the following participants:

1. Fairview Ridges Hospital (FYE 12/31/2008) appealing from an original NPR dated November 6, 2012; and

2. Fairview Northland Regional Medical Center (FYE 12/31/2008) appealing from an original NPR dated November 13, 2012.

The Medicare Contractor filed a Jurisdictional Challenge (April 9, 2013) regarding the Part C Days in the *Medicaid* Fraction issue.[1]

[1] The Providers also have a separate appeal of the 2008 Medicare Fraction for Medicare HMO Days CIRP in PRRB appeal in 13-0944GC.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor asserts that the Board does not have jurisdiction over the Part C days in the Medicaid fraction issue for either Provider because there were no audit adjustments proposed that related to the issue. The Medicare Contractor argues the Providers have both failed to preserve their right to claim dissatisfaction with the Medicaid fraction because they failed to claim or protest the exclusion of Medicare Advantage Days from the numerator of the Medicaid fraction as required. The Medicare Contractor cites to 42 C.F.R. § 405.1835(a)(1)(ii) in support of its position.

Board Decision

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

At issue in this dispute is whether the Provider meets the dissatisfaction requirement for Board jurisdiction.

Part C Days in the Medicaid Fraction

The Board finds it has jurisdiction over the Providers' appeals from the NPRs for the Part C Days issue in both the SSI/Medicare and Medicaid Fractions.

The Group Issue statement describes the Part C Days in the Medicaid fraction issue as follows:

> The provider argues the Secretary did not follow Congressional intent of the DSH fraction with regards to the Medicare Advantage program ((CFR 422.50(a)(1)) and (42 USC 1395ww(d)(5)(F)(vi)(I) and (II)) or apply appropriate procedures when introducing new rulemaking (42 USC 1395hh(a)(4). The Secretary had conflicting outcomes in the 2003 Notice of proposed rulemaking and 2004 notice final rulemaking in regards to the handling of the Medicare Advantage days in both the Medicare and Medicaid fractions. The final rulemaking failed to provide sufficient explanation on why the opposite interpretation was arrived between the two rulemaking documents or address the financial implication being imposed to providers.
>
> No audit adjustments are made on the final Notice of Program Reimbursement relating to this issue because the Provider self-disallowed Medicare Advantage patient days in the Medicaid fraction based on fiscal intermediary instructions and the Secretary's interpretation and rulemaking clarification written in Federal Register Vol. 96, No. 154, page 49099.[2]

[2] CN 13-0939GC, *Model Form B – Group Appeal Request* (March 4, 2013), Tab 2.

The Board finds that the Providers have cited to adjustment of the DSH SSI percentage in the Medicare/SSI Fraction for Medicare HMO Days CIRP Group (Case No. 13-0944GC) and per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[3] Thus, pursuant to *Allina*, if the provider were to be successful in its regulatory challenge, then the Part C days would have to be moved from the SSI fraction to the Medicaid fraction. Accordingly, the Board finds that it has jurisdiction over the complete Part C days issue as the Provider has met the dissatisfaction requirement for this issue.

The Board will issue a separate decision regarding the applicability of CMS Ruling 1739-R as it applies to the Part C Days in the Medicaid fraction issue in this case, along with the Part C Days in the SSI fraction issue which is pending under Case No. 13-0944GC, 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 this appeal.

Board Members
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD

4/27/2022

X Clayton J. Nix

Clayton J. Nix
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

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

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RE: **Denial of Bifurcation Requests**
Sutter Health 2009 DSH - SSI Ratio Dual Part C CIRP Group
Case No. 16-2071GC

Dear Mr. Jaeger and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") reviewed Sutter Health's 5 bifurcation requests received in October 2018. Sutter Health requests to bifurcate the following providers from Case No. 16-2071GC and transfer the providers to Case No. 18-0568GC:

- St. Luke's Hospital (05-0055)
- Summit Medical Center (05-0043)
- Alta Bates Medical Center (05-0305)
- Memorial Hospital Modesto (05-0557)
- CPMC – Davies (05-0008)

Both of these group cases appeal Part C Days issues. Case No. 16-2071GC argues that Part C Days should be excluded from the DSH SSI fraction, while Case No. 18-0568GC argues that Part C Days should be included in the DSH Medicaid fraction. Sutter Health states that it "maintains that the two issues are fundamentally the same," but was unsure whether the Board would consider them to be two separate issues since there are two fractions involved. For the reasons listed below, the Board hereby denies the bifurcation requests.

APPLICABLE LAW

Pursuant to 42 C.F.R. § 405.1867 (2020), the Board must comply with CMS Rulings issued under the authority of the Administrator. One such Ruling is CMS-1739-R (Aug. 17, 2020), which addresses Medicare Part C Days in the DSH calculation (the DSH calculation consists of two fractions, the SSI fraction and the Medicaid fraction) for years prior to October 1, 2013 (or, fiscal year 2014). The Ruling applies to the same issue raised in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (Jun. 3, 2019) (*Allina*): whether patient days associated with patients enrolled in Part C should be included in the SSI fraction. The Ruling also states that the D.C. Circuit found that the Secretary is required to account for Part C days in the DSH calculation by including them in one fraction and excluding them from the other. The Administrator states that the Board "must remand each qualifying appeal" to the Medicare contractor for CMS to determine whether beneficiaries enrolled in Part C are "entitled to benefits under Part A" and so must be included in the SSI fraction, or are not entitled and therefore included in the Medicaid fraction.

In addition to the Ruling, the Board regulations indicate that the matter at issue in a group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group. 42 C.F.R. § 405.1837(a)(2). Further, the regulations require a level of specificity in identifying issues under appeal. *See* § 405.1837(c)(2), (f)(2). The question for the Board, then, is whether the Part C Days issues, as raised by Sutter Health, are two issues that necessitate bifurcating the 5 providers.

ANALYSIS

In order for CMS-1739-R to apply to the cases under consideration, they must meet the time and issue requirements. The groups appealed for cost report year 2009. Since the patient discharges in question occurred prior to October 1, 2013, they fall under the purview of the Ruling. Second, the issue in Case No. 16-2071GC is the improper inclusion of Part C days in the SSI fraction. The issue in Case No. 18-0568GC is that all Medicare Dual Eligible Part C days should be included in the Medicaid fraction. Consequently, the issue of the proper placement of Part C days in the DSH calculation is under appeal in both cases. This is the same issue addressed by the Ruling. Therefore, CMS-1739-R serves as the authority in determining whether the Part C days issue should be bifurcated as requested.

The Ruling indicates that Part C days will be placed in either the SSI fraction *or* the Medicaid fraction. The location of Part C days in the DSH calculation is the singular issue. The D.C. Circuit in *Allina* confirmed this by stating that "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[1] Since the issues in Case Nos. 16-2071GC and 18-0568GC are not exclusive of one another, it is not necessary that the Board bifurcate the 5 providers in order to transfer them to Case No. 18-0568GC. The Board's conclusion follows the Board regulations that require a group to have a single matter at issue.

DECISION

The Ruling describes Sutter Health's Part C Days issue—based on *Allina*—as one issue. The Board hereby denies Sutter Health's requests to bifurcate St. Luke's Hospital (05-0055); Summit Medical Center (05-0043); Alta Bates Medical Center (05-0305); Memorial Hospital Modesto (05-0557); and, CPMC – Davies (05-0008) in order to transfer them to Case No. 18-0568GC. The Board finds that CMS-1739-R is applicable to Case Nos. 16-2071GC and 18-0568GC and will issue a remand determination for these cases under separate cover.

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

4/28/2022

X Clayton J. Nix

Clayton J. Nix
Chair
Signed by: PIV

cc: Wilson C. Leong, Federal Specialized Services

[1] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1108 (D.C. Cir. 2014).

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RE: ***Jurisdictional Decision***
Wilkes Regional Medical Center (Provider No. 34-0064)
FYE 9/30/2012
Case No. 16-0054

Dear Mr. Ravindran,

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

Pertinent Facts:

Wilkes Regional Medical Center submitted a request for hearing on October 6, 2015 from a Notice of Program Reimbursement ("NPR") dated April 8, 2015. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH SSI Fraction Managed Care Part C Days
- Issue 4: DSH SSI Fraction Dual Eligible Days
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicaid Fraction Managed Care Part C Days
- Issue 7: DSH Medicaid Fraction Dual Eligible Days
- Issue 8: Outlier Payments – Fixed Loss Threshold

On June 22, 2016, the Provider transferred issues 2, 3, 4, 6, 7, and 8 to group appeals. Issue 2, DSH SSI Percentage (Systemic Errors), was transferred to PRRB Case No. 15-3319GC – QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group. After transfers, Issues 1 and 5 are the sole remaining issues.

The Medicare Contractor submitted a jurisdictional challenge on Issue 1 on March 7, 2022.[1] The Provider did not submit a responsive brief.

In its appeal request, the Provider summarizes Issue 1, the DSH SSI Percentage (Provider Specific) issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[2]

Similarly, the Provider describes Issue 2, the DSH SSI Percentage (Systemic Errors) issue, which has been transferred to Case Number 15-3319GC, as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider further contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] The jurisdictional challenge superseded a jurisdictional challenge that was submitted on May 25, 2018.
[2] Individual Appeal Request, Issue 1 Issue Statement.

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

The Provider submitted its Final Position Paper on February 10, 2022. It did not address Issue 2 in its Final Position Paper.

Medicare Contractor's Contentions

The Medicare Contractor contends Issue 1 should be dismissed from this case. According to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. As noted above, the Provider transferred Issue 2 to Group Case No. 15-3319GC, "*QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group*." The Medicare Contractor contends that the portion of Issue 1 related to SSI data accuracy should be dismissed because it is duplicative of the issue under appeal in Group Case No. 15-3319GC.[4]

The Medicare Contractor also contends that the portion of Issue 1 related to SSI realignment should also be dismissed. The Medicare Contractor contends that the Provider's appeal over SSI realignment has been abandoned or withdrawn in accordance with Board Rule 25.3. The Medicare Contractor also notes that the Provider's fiscal year end is the same as the federal fiscal year end (September 30). The result of the Medicare computation based on the Provider's fiscal year end would therefore be the same as the Medicare computation based on the federal fiscal year end. Alternatively, the Medicare Contractor asks the Board to dismiss this issue as premature consistent with other recent jurisdictional decisions.[5]

Board Decision:

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

The Board finds that it does not have jurisdiction over Issue 1, the DSH SSI Percentage (Provider Specific) issue. This jurisdictional analysis of Issue 1 has two components:

[3] Individual Appeal Request, Issue 2 Issue Statement.
[4] Medicare Contractor's jurisdictional challenge at 7.
[5] Medicare Contractor's jurisdictional challenge at 7.

1. The Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and

2. The Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

A. First Aspect of Issue 1

The Board finds that the first aspect of Issue 1- the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage - is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 15-3319GC, "*QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group*. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8] Issue 2, transferred to group Case No. 15-3319GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 transferred to Case No. 15-3319GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Jul. 1, 2015), the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 15-3319GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[9] Provider is incorrect in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3319GC.

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[6] Individual Appeal Request, Issue 1.
[7] Individual Appeal Request, Issue 1.
[8] Individual Appeal Request, Issue 1.
[9] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[10] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 by explaining the nature of any alleged "errors" in its Final Position Paper and including *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[11] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its Final Position Paper on February 10, 2022, in direct violation of Board Rule 25.2.2:

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

Accordingly, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case No. 15-3319GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH SSI Percentage (Provider Specific) issue. In the alternative, the Board dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the Provider abandoned the SSI realignment portion of Issue 1 as it did not brief the issue in its final position paper.

Board Rule 27 addresses final position papers. Specifically, the content of final position papers is addressed at 27.2:

> The final position paper should address **each issue remaining in the appeal**. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.[12]

[10] (Emphasis added.)
[11] (Emphasis added.)
[12] (Emphasis added.)

Board Rule 25.3 Filing Requirements to Board states the following:

> If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn.

As the Provider abandoned the SSI realignment portion of Issue in its final position paper, the Board dismisses the SSI realignment portion of Issue 1 from the appeal.

The Board also notes that the Provider's fiscal year end is September 30, which is the same as the federal fiscal year. As such, realignment would have no effect, as the underlying data would not change, and the months included would not change.

Conclusion:

The Board dismisses Issue 1, the DSH SSI Percentage (Provider Specific) issue, in its entirety from this appeal. The case remains open given that another issue, Issue 5 - DSH Medicaid Eligible Days, remains pending.

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

4/27/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Doctors Hospital (36-0152)
FYE 6/30/2013
Case No. 16-1555

Dear Mr. Johnston,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI Ratio Realignment issue because there is no final determination from which the Provider is appealing. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

Doctors Hospital ("Provider") filed an Individual Appeal Request on March 9, 2016. The original appeal contained the following three (3) issues and was appealing from a Notice of Program Reimbursement dated November 11, 2015:

1. Bad Debts (Indigency Determination)
2. Bad Debt (Inconsistent Collection Efforts)
3. Use of Provider's Cost Report Year for Calculation of DSH Percentage ("SSI Realignment")

Issues 1 and 2 were both transferred to group appeals on April 7, 2022.

In its third issue, the Provider sought "to preserve its rights to obtain a reopening and realign the DSH percentage calculation period" pursuant to 42 C.F.R. 412.106(b)(3). It notes that the Medicare Contractor used Provider data from federal fiscal year ("FY") 2013 (October 1, 2012 – September 30, 2013) for the purposes of determining its eligibility for and amount of reimbursement due to the Provider for its Disproportionate Share Hospital ("DSH") adjustment for FY 2013. It argues it would be due additional reimbursement if the calculation was used data from its fiscal year (July 1, 2012 – June 30, 2013). A hearing has been set for April 29, 2022.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied

with the final determination of the 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 therefore, the Board is dismissing 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 MAC. Without this request it is not possible for the Medicare Contractor to have issued a final determination from which the Provider could appeal.

Since this is the sole remaining issue, the case is being 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:

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For the Board:

4/28/2022

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