DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Dismissal of Duplicate Appeal***
John C. Lincoln Health Network 2010 DSH SSI Part C Days CIRP Group
Case No. 14-3189GC

Dear Mr. Taylor and Mr. Bloom:

The above-referenced common issue related party ("CIRP") group appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Board finds the case is duplicative, and dismisses the appeal.

Background

The Provider Reimbursement Review Board (the "Board") received the Group Representative's Request for Hearing dated April 14, 2014, related to Notices of Program Reimbursement ("NPR") dated October 17, 2013.[1] The providers appealed the following issue:

> …The Provider disputes the inclusion of MA days in the SSI ratio and requests these days along with the additional identified dual-eligible Medicare/Medicaid days should be included in the Medicaid ratio [emphasis added] Since this issue impacts both the SSI ratio and the Medicaid ratio, the Provider is appealing both….[2]

The CIRP group was fully formed with two participants in 214, John C. Lincoln Hospital North Mountain, 03-0014 and John C. Lincoln Deer Valley, 03-0092, both for FY 12/31/10.

Upon review of the documentation, pursuant to CMS Ruling 1739-R, it was noted that the two providers in this CIRP group had already been granted EJR in a previous CIRP group case for the *same* issue and year.

[1] Provider's Request for Appeal (Apr. 14, 2014), Case No. 14-3189GC.
[2] *Id*. at Tab 3, Issue Statement.

Another CIRP group appeal, for the same issue and year and the same participants, was filed on December 23, 2014, by a *different* representative, Quality Reimbursement Services ("QRS"). That CIRP group appeal was under Case No. 15-0752GC entitled *QRS John C. Lincoln Health Network 2010 Medicaid Fraction/Medicare Managed Care Part C Days CIRP Group*. On June 26, 2019, QRS confirmed the CIRP it was complete and simultaneously EJR for the same issue and same participants.[3] Specifically, in 15-0752GC, the request for EJR stated the issue as:

> [W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.[4]

QRS requested EJR in Case No. 15-0752GC,[5] explaining that "[b]ecause the Secretary has not acquiesced to the decision in *Allina [I],* the 2004 regulation requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B). (The '2004 Rule') The Board is bound by the 2004 rule."[6] Accordingly, the Providers contended that the Board should grant their request for EJR.

On July 18, 2019, the Board granted the EJR request for the Part C Days issue in Case No. 15-0752GC which included the two providers and same fiscal years as in the current case.[7]

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> 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*.[8]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[9] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

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[3] Provider 03-0014, John C. Lincoln North Mountain Hospital, and Provider 03-0092, John C. Lincoln Deer Valley Hospital, were previously included in Case No. 15-0752GC.
[4] Request for Expedited Judicial Review (Jun. 26, 2019), Case No. 09-1980GC; *Id*., Case No. 15-0752GC.
[5] Included in a consolidated EJR request under lead Case No. 09-1980GC.
[6] Request for Expedited Judicial Review (Jun. 26, 2019), Case No. 09-1980GC; *Id*., Case No. 15-0752GC.
[7] Board's EJR Determination (Jul. 18, 2019), Case No. 09-1980GC, *et al*.
[8] 42 C.F.R. § 405.1837(b)(1) (emphasis added).
[9] 42 C.F.R. § 405.1837(e)(1).

> 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.[10]

On June 26, 2019, QRS certified that the Lincoln CIRP group under Case No. 15-0752GC was complete and simultaneously requested EJR. Pursuant to this certification, any additional Lincoln providers outside of this CIRP group for the same issue and year would be part of a duplicate case, violating the CIRP regulations at 405.1837(b)(1) and (e). As the CIRP group under Case No. 14-3189GC is for the *same* chain, for the *same* issue (Part C Days), ***and*** for the *same* fiscal year (2010), any providers within Case No. 14-3189GC are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

Furthermore, the Board finds that Case No 14-3189GC is a duplicate of Case No. 15-0752GC as the EJR request for which the Board granted EJR, as well as the Board's EJR decision itself, clearly encompassed the *complete* Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[11] 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.[12] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[13] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses Case No. 14-3189GC in its entirety, because the issue was disposed of through the EJR of PRRB of 15-0752GC for both Providers in this CIRP group appeal and because Case No. 14-3801GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e). The Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[10] *Id*. (emphasis added).
[11] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[12] 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.
[13] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Board Members Participating:

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

For the Board:

8/4/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS

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RE: ***Dismissal of Duplicate Appeal***
DH FY 2006 Dual Eligible Part C Days in SSI Ratio Issued 3/16/12 CIRP Group
Case No. 13-0812GC

Dear Mr. Knight and Ms. Frewert:

The above-referenced common issue related party ("CIRP") group appeal for Dignity Health ("DH") includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group is DH and DH has already been granted EJR for the issue under appeal, and for this specific Fiscal Year. As such, the above DH CIRP group appeal violates the CIRP regulation, is duplicative, and must be dismissed.

Background

The Board received the Group Representative's Request for Hearing dated February 15, 2013 to establish a DH CIRP group. The Board assigned this DHS CIRP group appeal to Case No. 13-0812GC. The DH CIRP group appeal request contained the following issue statement regarding the appealed Part C Days issue:

> *The Provider contends CMS' new interpretation of including Medicare Dual Eligible Part C Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the Northeast Hospital decision… The Provider maintains the position all Medicare Dual Eligible Part C Days should be included in the Medicaid patient day ratio of the Medicare DSH and LIP payment calculations….*[1]

On October 30, 2020, the DH Providers' representative submitted an updated Schedule of Providers and request for Expedited Judicial Review ("EJR"). On November 27, 2020, the Board

[1] Providers' Group Appeal Request, at Issue Statement (Feb. 15, 2013).

denied the EJR because the case was subject to remand (via CMS Ruling 1739-R), and notified the provider the case would be remanded under separate cover.

In its review of the documentation for the remand of these issues, the Board noted that the Common Owner of this group has *already* been granted EJR for the Part C days issue for this specific Fiscal Year in a separate CIRP group case under Case No. 17-1928GC entitled "Dignity Health 2006 Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group."

EJR in 17-1928GC

On May 10, 2019, the group representative in Case No. 17-1928GC requested EJR for the following issue:

> *[W]hether Medicare Part C patients are 'entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator* ***or vice-versa****.*[2]

On June 6, 2019, the Board granted the ("EJR") request in Case No. 17-1928GC[3] entitled *Dignity Health 2006 Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group*, representing the same parent organization, Dignity Health, and the same fiscal year as in case 13-0812GC, the case at issue.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> *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.*[4]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[5] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

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[2] Expedited Judicial Review Request (May 10, 2019), PRRB Case no. 14-1290GC, *et al*. (emphasis added) (The EJR request further clarified in its introduction, "[t]he Hospitals seek expedited judicial review ("EJR") of the rule including Part C days in the DSH Medicare Part A/SSI fraction and excluding Medicaid-eligible Part C days from the numerator of the Medicaid fraction.").
[3] EJR Determination (May 8, 2019), PRRB Case No. 14-3423GC, et al.
[4] 42 C.F.R. § 405.1837(b)(1).
[5] 42 C.F.R. § 405.1837(e)(1).

> *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.*[6]

Pursuant to the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e), processing of the EJR on the Board's part dictates that the group is considered fully formed; Any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[7] As Case No. 13-0812GC was part of the same common ownership, for the same issue (Part C Days), and for the same fiscal years, any providers within that case are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

Furthermore, the Board notes that the EJR requests for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, i.e., both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[8] 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.[9] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[10] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH Part C Days issue from PRRB Case No. 13-0812GC because the issue was disposed of through the EJR of Case No. 17-1928GC and because Case No. 13-0812GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and dismisses the case.[11]

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[6] *Id*.
[7] *See* 42 C.F.R. § 405.1837(e) ("[w]hen 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.").
[8] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[9] 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.
[10] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).
[11] The Board notes that there is a third CIRP group for Dignity Health 2006 Part C Days, case 17-1574GC, which will be addressed under separate cover.

The Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

8/6/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS

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Bruce Snyder
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RE: ***Jurisdictional Decision in Part***
Hamot Medical Center (39-0063, 6/30/2007), *as a participant in*
HRS 06 07 DSH/Medicare Managed Care Part C Days Group
PRRB Case No. 11-0508G

Dear Ms. Goron and Mr. Snyder,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal as part of its review of jurisdiction for remands guided by CMS Ruling 1739-R for Part C Days issues. The group appeal contains at least one Provider that appealed from a Revised Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Board received the Providers' Group Appeal Request on February 25, 2011, which included a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

Hamot Medical Center (39-0063, 6/30/2007) filed an appeal request dated November 19, 2010 with the Board from a revised NPR dated June 2, 2010. The Provider requested to transfer the Part C days issue to this group appeal on February 25, 2011 as part of the group appeal request.

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

> respect to intermediary determinations) or by the reviewing entity that made the decision (as described in § 405.1885(c) of this subpart).

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

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

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

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

The Board finds that it does not have jurisdiction over Hamot Medical Center's appeal from its revised NPR, as Part C days were not specifically adjusted in the Provider's revised NPR. The revised NPR regulations make clear that a Provider can only appeal items that are specifically adjusted from a revised NPR. Pursuant to its policy announced in the FY 2005 IPPS Final Rule, Part C days are counted in the SSI fraction of the DSH calculation. Here, the Board can find that it does not have jurisdiction over Part C days in the SSI or Medicaid fractions because there is no evidence that Part C days, as counted in the SSI fraction, were adjusted in the revised NPR as required by 42 C.F.R. § 405.1889(b). Indeed, there is no evidence that the SSI fraction itself was adjusted. The Provider cites to Audit Adjustment No. R1-800 as listed in "Audit Adjustment Report" attached to the appeal request as the adjustment relevant to the Part C Days issue.[1] The explanation for this adjustment simply reads "Allowable disproportionate share percentage – To

[1] The Provider did not submit a copy of the Notice of Reopening that preceded the revised NPR at issue or any other evidence that would demonstrate that Part C Days as counted in the SSI fraction were adjusted.

Adjust DSH to audited amount." Review of the Audit Adjustment Report suggests that Medicaid eligible days as reported in the Medicaid fraction were adjusted (and not the SSI fraction). Accordingly, the Board hereby dismisses the Provider, Hamot Medical Center (39-0063) from Case No. 11-0508G because Hamot did not have the right to appeal the Part C Days issue based on the revised NPR pursuant to 42 C.F.R. § 405.1889(b). In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[2] Case No. 11-0508G remains open, and remand pursuant to CMS Ruling 1739-R will be addressed under separate cover.

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

Board Members Participating:

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

For the Board:

8/10/2021

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

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RE: ***Dismissal of Duplicate Appeal***
HealthQuest 2010 Medicaid Fraction Medicare Advantage Part C Days Group
PRRB Case No. 15-1451G

Dear Mr. Dreyfus and Ms. Frewert:

The above-referenced appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Board finds the case is duplicative, and dismisses the appeal.

Background

The Provider Reimbursement Review Board ("Board") received the Group Representative's Group Appeal Request on February 13, 2015. The providers appealed the following issue:

> The [providers contend] that all Medicaid Eligible Medicare Part C Days (MA) should be included in the Medicaid patient day ratio of the Medicare DSH calculations.

Legal Basis

On April 1, 2014 the United States Court of Appeals for the District of Columbia Circuit addressed the issue of whether Medicare Part C (Medicare Advantage or "MA") days should be included in the Medicare fraction or the Medicaid fraction of the disproportionate share calculation. *Allina Health Services, et. al. v. Sebelius*, USCA Case No. 13-5011. The Appeals Court ruled that the promulgation of the regulation requiring including of MA days in the Medicare fraction was improper since it violated the Administrative Procedures Act because the industry was not afforded the ascribed opportunity for comment on the Final Rule.

> As a result, the Appeals Court vacated the rule requiring inclusion of MA days in the Medicare fraction.
>
> Also at issue in Allina was the placement of the dual eligible MA patients after removal from the Medicare fraction. The lower Court had directed the Secretary to automatically place the dual eligible MA in the Medicaid ratio *Allina Health Servs. V. Sebelius*, No. 10-1463 (RMC)(D.D.C. Nov. 15, 2012). The Appeals Court reversed the lower Court's direction to the Secretary, instead leaving the remedy to the Secretary's discretion. However, the Appeals Court made clear, and we contend that prior Court rulings and logical deduction leave no other option than placing the dual eligible MA in the Medicaid fraction.

As this is an optional group appeal, the appeal was fully formed after one year, on February 19, 2016.[1]

On February 3, 2017, the group representative withdrew the two providers below from Case No. 15-1451G by stating "[w]e hereby withdraw [the following Provider] from appeal 15-1451G":

- Santa Monica – UCLA Medical Center (Provider No. 05-0112) ("Santa Monica");
- Coast Plaza Medical Center (Provider No. 05-0219) ("Coast Plaza");[2]

Almost 3 years later, on January 20, 2020, the Provider filed a Motion for Reinstatement for the above Providers. On March 15, 2021, pursuant to Board Rule 47.1, the Board denied reinstatement of the two Providers because "the Group Representative: (a) voluntarily and without qualification withdrew the 2 providers; (b) admits he was at fault for this withdrawal through the use of the words 'erroneously withdrawn' and 'in error'; and (c) filed the Motion to correct the alleged 'error' only after an unexplained years-long delay."[3]

On February 6, 2020, in response to the Board's Request for Comments Regarding Potential Own Motion Expedited Judicial Review (EJR) in various optional groups, the Providers' representative requested transfer of two Providers to a CIRP group due to common ownership, and these transfers were completed on March 25, 2020. On February 7, 2020, the Providers' representative submitted an updated Schedule of Providers to reflect the previously discussed withdrawals and transfers from the case.

On March 3, 2015, the Group Representative, HealthQuest Consulting, Inc., filed another group appeal with the Board for the HealthQuest 2010 Medicare Fraction Medicare Advantage Part C Days Group, 15-1683G, which was deemed complete on March 13, 2016. The Group Issue reads:

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[1] PRRB Rule 19.1 (July 1, 2015) states: "In optional group appeals, the Board will set the deadline to complete the group, generally 12 months from the date of the group hearing request."
[2] *See* Provider's Request for Reinstatement, at Ex. 3 (Jan. 20, 2020).
[3] *See* Board's Motion to Reinstate Withdrawn Providers Decision Letter (Mar. 15, 2021).

> The Providers dispute the SSI percentage developed by CMS and utilized by the MAC in the calculation of Medicare DSH payment. CMS has included Medicare Advantage patient days in the SSI rations for FFY 2006 and subsequent years.
>
> The providers contend that all Medicaid Eligible Medicare Part C Days (MA) should be included in the Medicaid patient day ratio of the Medicare DSH calculations, and Medicare Part C days should be entirely excluded from the SSI ratio.

The legal basis of the issue statement in Case No. 15-1683G contains the ***identical*** legal basis as in Case No. 15-1451G, quoted above.

The Board remanded Case No. 15-1683G on February 3, 2021, pursuant to CMS Ruling 1739-R and closed the appeal. There were 5 Providers that were remanded as part of Case No. 15-1683G:

- 05-0169, Presbyterian Intercommunity (9/30/2010)
- 10-0002, Bethesda Memorial Hospital (9/30/2010)
- 05-0219, Coast Plaza Doctors' Hospital (12/31/2010)
- 05-0393, Downey Regional Medical Center (6/30/20210)
- 05-0704, Mission Community Hospital (6/30/2010)

The subject group case, Case No. 14-1451G, has four remaining participants in the group. All four of these participants were also remanded pursuant to CMS Ruling 1739-R as participants in Case No. 15-1683G for the same year.

Board's Analysis and Decision

The Board finds that Case No. 15-1451G is a duplicate of Case No. 15-1683G, as both cases encompassed the same issue, i.e., the Part C DSH issue. The Board notes that the Board's Own Motion EJR Notice as well as the Board's decisions to remand the group case clearly encompassed the ***complete*** Part C DSH issue, i.e., both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"),[4] 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.[5] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[6] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue

[4] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[5] 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.
[6] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross*

dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses Case No. 15-1451G because the DSH Part C Days issue for the participants in that group was disposed of through the remand of Case No. 15-1683G which encompassed these *same* participants and fiscal year. Accordingly, the Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/10/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS

BlueShield Ass'n, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision in Whole***
Doctors Hospital (Prov. No. 36-0152)
FYE 6/30/2012
Case No. 15-2232

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to a Jurisdictional Challenge filed by the MAC regarding Doctors Hospital's ("Provider") issues in its individual appeal from its Notice of Program Reimbursement ("NPR"). The Board's decision is set forth below.

Background:

The Provider Reimbursement Review Board (the "Board") received the Provider's Request for Hearing dated April 10, 2015, related to a NPR dated October 15, 2014.[1] The Provider's Request for Hearing included three issues, and a fourth issue was added on June 11, 2015:

- Issue 1: Bad Debt- Indigence Determinations[2]
- Issue 2: Bad Debt- Inconsistent Collection Effort[3]
- Issue: 3: Effect of Prior Year Adjustments
- Issue 4: DSH- Medicaid Fraction- Dual Eligible Days[4]

On April 29, 2016, Issue #4 was transferred to group case 16-1536GC. On March 11, 2019, the Provider transferred Issue #1 to group case 19-1821GC and Issue #2 to group case 19-1792GC. Leaving only Issue #3 in the appeal.

The MAC filed a Jurisdictional Challenge on May 13, 2016, challenging whether the Board has jurisdiction over Issues #3 and 4.[5] Because Issue #4 was subsequently transferred to group case 16-1536GC, the only remaining issue subject to the Jurisdictional Challenge is Issue #3. The challenge to Issue #3 centers on whether the Provider's appeal issue for the "effect of prior year

[1] Provider's Request for Appeal (Apr. 10, 2015), PRRB Case No. 15-2232.
[2] Issue #1 was transferred to Group Case No. 19-1821GC.
[3] Issue #2 was transferred to Group Case No. 19-1792GC.
[4] Issue #4 was transferred to Group Case No. 16-1536GC.
[5] MAC's Jurisdictional Challenge (May 13, 2016).

adjustments" is in compliance with Medicare regulations and PRRB rules. The Provider did not respond to the challenge.

MAC's Jurisdictional Challenge

The MAC argues that the provider is not appealing any specific adjustment in the NPR. Instead, the provider seeks to preserve its future appeal rights of this NPR in case something did occur in the preceding years' NPRs. Appeal regulations do not allow providers to file an appeal to preserve future appeal rights. The issue itself as stated by the provider "the potential impact that 'certain prior year issues' might have on the reimbursement in the fiscal year in dispute" indicates no dispute of the NPR it has appealed.

The Board elaborates the regulatory 42 C.F.R. §§ 405.1835-105.1889 requirements by issuing the Board Rules. The Board Rules require the Provider identify the specific issues, specify the basis for contending that the findings and conclusions, and show how the payment should be determined differently. The MAC contends that the provider has clearly failed to adequately identify their dispute as a specific issue. The provider fails to follow Board rule 7.1, Rule 7 .1 - NPR or Revised NPR Adjustments.

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

The MAC respectfully requests the Board dismiss this issue as it is not in compliance with 42 C.F.R. § 405.1835 and Board Rules.

Board's Analysis and Decision

The Board finds that it does not have jurisdiction over Issue No. 3, the Effect of Prior Year Adjustments issue and dismisses the "flow-through issue" as being in violation of Board Rules.

A provider is entitled to a hearing before the Board if: (1) such provider is dissatisfied with a final determination of the Medicare Contractor as to its amount of total program reimbursement due the provider; (2) the amount in controversy is $10,000 or more; and, (3) such provider files a request for a hearing within 180 days after notice of the final determination.[6] The related regulations and Board rules describe in more detail what is required in order to file a hearing request with the Board. 42 C.F.R. § 1835(b) (2015) delineates the content requirements for a request for hearing and states in pertinent part:

> (b) *Contents of request for a Board hearing on final contractor determination*. The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing to the

[6] 42 U.S.C. § 1395oo(a).

> Board, and the request must include the elements described in paragraphs (b)(1) through (b)(4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the contractor's or Secretary's determination under appeal.
>
> (2) **An explanation** (for each specific item at issue, see paragraph (a)(1) of this section) **of the provider's dissatisfaction** with the contractor's or Secretary's determination under appeal, including an account of all of the following:
>
> > (i) **Why the provider believes Medicare payment is incorrect for each disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).
> >
> > (ii) **How and why** the provider believes Medicare **payment must be determined differently** for each disputed item.
> >
> > (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement or payment sought for the item.
>
> (3) A copy of the contractor or Secretary determination under appeal, **and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section**.[7]

The Board Rules state, "[f]or <u>each</u> issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction."[8] Board Rule 7.1A requires a concise issue statement describing the adjustment, including the adjustment number; why the adjustment is incorrect; and, how the payment should be determined differently.[9] Alternatively, if the Provider does not have access to the underlying information, it is to describe why that information is not

[7] (Bold emphasis added.)
[8] PRRB Board Rules, Rule 7 (Mar. 1, 2013).
[9] *Id.* at 7.1A.

available.[10] These requirements are reiterated in Model Form A, the Individual Appeal Request form, which was utilized by the Provider to file its appeal.[11] Model Form A provides that:

> The statement of the issue(s) must conform to the requirements of the regulations found at 42 C.F.R. § 405.1835 et seq. and the Board's Rules and must include: (1) a description of the issue; (2) the audit adjustment number(s), if applicable, or other evidence required by 42 C.F.R. § 405.1835 (a)(1)(ii); (3) the amount in controversy; and (4) a statement identifying the legal basis for the appeal (with citation to statutes, regulations and/or manual provisions).[12]

The Provider did not appeal a specific issue, but rather a "flow-through effect" from any prior appeals. The Provider did not cite to any audit adjustments or specify which determination(s)/issue(s) from other appeals it was referring to. As explained in its appeal request, the Provider does not have access to the information necessary to more specifically describe the MAC's adjustments because future events, such as certain resolutions and potential re-openings, could affect such underlying data. The Provider in no way "perfects" or specifically clarifies any issues and does not make any claims that permit the Board to make a determination in this case. As a result, the Board is unable to determine what issue is in dispute and finds that the appeal lacks specificity as required by 42 C.F.R § 405.1835(b) and Board Rule 7.1A. Accordingly, the Board hereby dismisses Issue 3 from the appeal.

As this was the sole remaining in the appeal, the Board closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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Robert A. Evarts, Esq.
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For the Board:

8/10/2021

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Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

[10] *Id*. at 7.1B.
[11] *See* Model Form A, PRRB Board Rules, at 48-51.
[12] *Id*. at 50. (Section 8 of Model Form A describes the requirements for appealed issues).

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RE: ***Jurisdictional Determination***

19-1810GC	Montefiore Health CY 2016 Rehab LIP Dual Eligible Days CIRP Group
19-1809GC	Montefiore Health CY 2016 Rehab LIP Medicare Advantage Days CIRP Group
19-1808GC	Montefiore Health CY 2016 Rehab LIP Post 1498-R Medicare Part A/SSI% CIRP Grp
20-0600GC	Montefiore Health CY 2017 Rehab LIP Dual Eligible Days CIRP Group
20-0602GC	Montefiore Health CY 2017 Rehab LIP Post 1498-R Medicare Part A/SSI% CIRP Grp
20-0577GC	Montefiore Health CY 2017 Rehab LIP Part C Days CIRP Group
21-1417GC	Montefiore Health CY 2018 Rehab LIP Post 1498R Medicare Part A/SSI% CIRP Grp
21-1415GC	Montefiore Health CY 2018 Rehab LIP Medicare Advantage Days CIRP Group
21-1416GC	Montefiore Health CY 2018 Rehab LIP Dual Eligible Days CIRP Group

Dear Ms. Webster and Ms. Decker:

The above-captioned nine (9) common issue related party ("CIRP") group cases involve the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2016 through 2018.[1] The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[2] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issues and dismisses the instant CIRP group appeals.

Pertinent Facts

The Providers filed CIRP group appeals with the Board seeking to have patient days associated with a number of different issues including: Dual Eligible Days, Medicare Advantage/Part C Days, and Post 1498-R Medicare Part A/SSI Percentage, pertaining to fiscal years 2016 through

[1] Based on the fiscal years under appeal in these groups, the Providers are subject to the substantive claim requirements of 42 C.F.R. §§ 413.24(j) and 405.1873. However, based on the Board's conclusion that the Board's review of the LIP issues in these groups is precluded by statute, the Board need not reach the issue of whether the Providers properly made a substantive claim.

[2] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).

2018.[3] In all 9 CIRP group cases, while the issues vary, each issue concerns the Medicare Administrative Contractor's ("MAC") determination of the Providers' low income percentage adjustments under the prospective payment system for inpatient rehabilitation services (hereinafter known as "IRF-LIP"), for the specific days at issue.[4]

On its own Motion, the Board moves to dismiss these cases under the findings of the D.C. Circuit in *Mercy*. Accordingly, the LIP adjustment portion of each specific issue above is the pertinent issue in the group appeals as stated above.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[5]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[6] One of the ways in which

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[3] *See Request for Hearing*, at Tab 3, Issue Statement (Mar. 8, 2019), PRRB Case No. 19-1810GC; *See id.* at PRRB Case nos. 19-1809GC, 19-1808GC, 20-0600GC, 20-0602GC, 20-0577GC, 21-1417GC, 21-1415GC, 21-1416GC.
[4] *Id.*
[5] *Id.*
[6] *Id.* at 1064.

CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[7] The D.C. Circuits concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[8]

In the instant appeals, the Providers seek Board review of a number of the components utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeals of the LIP adjustment and dismisses the issues in the instant appeals that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Providers could bring suit in the D.C. Circuit.[9] Accordingly, the Board hereby closes the 9 CIRP groups under Case Nos. 19-1810GC, 19-1809GC, 19-1808GC, 20-0600GC, 20-0602GC, 20-0577GC, 21-1417GC, 21-1415GC, 21-1416GC and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/10/2021

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[8] *Mercy*, 891 F.3d at 1068.
[9] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

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RE: ***Dismissal of Duplicate Appeal***
Dignity Health 2006 Inclusion of Medicare Part C Days in SSI Ratio CIRP
Case No. 17-1574GC

Dear Mr. Chinea and Ms. Frewert:

The above-referenced common issue related party ("CIRP") group appeal for Dignity Health includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Provider Reimbursement Review Board ("PRRB" or "Board") has noted that the Common Owner of this group is Dignity Health, and Dignity Health has already been granted EJR for these issues and for this specific Fiscal Year. Set forth below is the Board's determination to dismiss the above CIRP group appeal.

Background

The Board received the Group Representative's Request for Hearing dated May 30, 2017 to establish a Dignity Health CIRP group. The Board assigned the CIRP group appeal to Case No. 17-1575GC. On October 30, 2020, the Providers certified the CIRP group was complete, submitted an updated Schedule of Providers, and requested Expedited Judicial Review ("EJR"). The providers' EJR request in this appeal contained the following regarding the appealed Part C Days issue:

> *Following the Allina decisions, the Providers ultimately seek to have Part C patient days excluded from the Part A/SSI fraction and included in the numerator of the Medicaid fraction to the extent Medicaid eligible….*[1]

On November 27, 2020, the Board *denied* the EJR because the case was subject to remand (via CMS Ruling 1739-R) and notified the provider the case would be remanded under separate cover.

[1] Providers' Petition for Expedited Judicial Review, at 19 (Oct. 30, 2020).

In its review of the documentation for the remand of these issues, the Board noted that the Common Owner of the group has *already* been granted EJR for the Part C Days issue for this specific Fiscal Year in a separate CIRP group case under Case No. 17-1928GC entitled "Dignity Health2006 Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group."

EJR in 17-1928GC

On May 7, 2019, the group representative certified the CIRP group was complete and submitted the Schedule of Providers. On May 10, 2019, the group representative in Case No. 17-1928GC requested EJR for the following issue:

> *[W]hether Medicare Part C patients are 'entitled to benefits under Part A, such that they should be counted in the Medicare Part A/SSI [Supplemental Security Income] fraction and excluded from the Medicaid fraction numerator* ***or vice-versa****.*[2]

On June 6, 2019, the Board granted the EJR request in Case 17-1928GC[3] entitled *Dignity Health 2006 Exclusion of Dual Eligible Part C Days from Medicaid Ratio CIRP Group*, representing the same parent organization, Dignity Health, and the same fiscal year as in Case No. 17-1574GC, the case at issue.

Board's Analysis and Decision

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> *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.*[4]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[5] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

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[2] Expedited Judicial Review Request (May 10, 2019), PRRB Case no. 14-1290GC, *et al*. (emphasis added) (The EJR request further clarified in its introduction, "[t]he Hospitals seek expedited judicial review ("EJR") of the rule including Part C days in the DSH Medicare Part A/SSI fraction and excluding Medicaid-eligible Part C days from the numerator of the Medicaid fraction.").
[3] EJR Determination (May 8, 2019), PRRB Case No. 14-3423GC, et al.
[4] 42 C.F.R. § 405.1837(b)(1).
[5] 42 C.F.R. § 405.1837(e)(1).

> *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.*[6]

In May 2019, the group representative certified Case No. 17-1928GC was complete and requested EJR. Pursuant to this certification, any additional Dignity Health providers outside this CIRP group for the same issue and year would be part of a duplicate case, violating the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e). As the CIRP group under Case No. 17-1574GC is for the same chain, the same issue (Part C days), and for the same fiscal year, any providers within Case No. 17-1574GC are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.[7]

Furthermore, the Board notes that the EJR request for which the Board granted EJR (as well as the Board's EJR decision itself) in Case No. 17-1928GC clearly encompassed the ***complete*** Part C DSH issue, i.e., both the Medicare and Medicaid fractions. Per the holdings in *Allina Health Servs. v. Sebelius* ("*Allina*"),[8] the DSH statute 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.[9] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit. Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board hereby **dismisses** the DSH Part C Days issue from PRRB Case No. 17-1574GC, as it was disposed of through the EJR of 17-1928GC and because Case No. 17-1574GC violated the CIRP regulations 42 C.F.R. § 405.1837(b)(1) and (e), and **dismisses** the case.[10]

The Board hereby closes the group appeal and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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[6] *Id*.
[7] *See* 42 C.F.R. § 405.1837(e) ("[w]hen 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.").
[8] 746 F.3d 1102, 1108(D.C. Cir. 2014).
[9] 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.
[10] The Board notes that there was a third CIRP group for Dignity Health 2006 Part C days, case 130-812GC that was dismissed by the Board on August 6, 2021.

Board Members Participating:

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Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

8/17/2021

X Clayton J. Nix

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RE: Jurisdictional Determination
21-0774GC – NYCHHC CY 2018 Improper LIP IRF Payment- SSI Matching Process CIRP
21-0772GC – NYCHHC CY 2018 Improper LIP IRF Pymt-Medicaid Eligible Days- Medicare Part C CIRP Group
21-0771GC – NYCHHC CY 2018 Improper LIP IRF Payment -Medicaid Timing Issue Days CIRP Group

Dear Mr. Willey and Ms. Decker:

The above-captioned three (3) common issue related party ("CIRP") group cases involve the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2018.[1] The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the 2018 decision of the U.S. Court of Appeals, District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[2] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Providers' Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issues and dismisses the instant CIRP group appeals.

Pertinent Facts

The Providers filed CIRP appeals with the Board seeking to have patient days associated with a number of different issues including: SSI Matching Process, Medicaid Eligible days, and Medicaid Timing Issue days, pertaining to fiscal year 2018.[3] In the three cases, while the issues vary, each issue concerns the Medicare Administrative Contractor's ("MAC") determination of

[1] Based on the fiscal years under appeal in these groups, the Providers are subject to the substantive claim requirements of 42 C.F.R. §§ 413.24(j) and 405.1873. However, based on the Board's conclusion that the Board's review of the LIP issues in these groups is precluded by statute, the Board need not reach the issue of whether the Providers properly made a substantive claim.
[2] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (June 8, 2018).
[3] *See Request for Hearing*, at Tab 3, Issue Statement (Feb. 19, 2021), PRRB Case No. 21-0774GC; *See id.* at PRRB Case nos. 21-0772GC, 21-0771GC.

the Providers' low income percentage adjustments under the prospective payment system for IRF-LIP, for the specific days at issue.[4]

On its own Motion the Board moves to dismiss these cases under the findings of the D.C. Circuit in *Mercy*. Accordingly, the LIP adjustment portion of each specific issue is the sole issue in the group appeals as stated above.

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2012), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2012), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, D.C. Circuit's decision in *Mercy*, answers this question and clarifies what is shielded from review in its analysis of this issue.[5]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[6] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the

[4] *Id*.
[5] *Id*.
[6] *Id*. at 1064.

establishment of the hospital's prospective payment rates.[7] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[8]

In the instant appeals, the Providers seek Board review of a number of the components utilized by the Medicare Contractor to determine the Providers' LIP adjustments. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeals of the LIP adjustment and dismisses the issues in the instant appeals that challenge this adjustment. In making this finding, the Board relied on the *Mercy* decision and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Providers could bring suit in the D.C. Circuit.[9] Accordingly, the Board hereby closes the 3 CIRP groups under Case Nos. 21-0774GC, 21-0772GC, 21-0771GC, and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/17/2021

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[7] *Mercy Hosp., Inc. v. Burwell,* 206 F. Supp. 3d 93, 102 (D.D.C. 2016).
[8] *Mercy*, 891 F.3d at 1068.
[9] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Dismissal and EJR Denial***
13-1682GC Good Shepherd Health System 2007 SSI Fraction Dual Eligible Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' request for expedited judicial review ("EJR") which was received on June 23, 2021, for the above-referenced common issue related party ("CIRP") group appeal. Set forth below is the Board's determination to dismiss this CIRP group case and to deny the EJR request.

Issue for which EJR is Requested:

The Providers, in the above-referenced group appeals are requesting EJR for the following issue:

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals . . . is whether the intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating [the Provider's] [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction [the Centers for Medicare and Medicaid Services ("CMS")] is compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization and, further, to furnish [the Provider] with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act. Furthermore, the Providers seeks a ruling that CMS has failed to provide them with adequate information to allow them to check and challenge CMS's disproportionate patient

> percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173 . . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in the Providers' DPP calculations, CMS continually violates its § 951 mandate.[1]

Procedural Background:

On April 12, 2013, McGladrey, LLP ("McGladrey") filed a group appeal request with the Board to establish the CIRP group that the Board assigned to Case No. 13-1682GC and initially there was only one provider – Marshall Regional Medical Center (Prov. No. 45-0032, FYE 9/30/2007).[2] The CIRP group issue statement as presented by Marshall Regional Medical Center was as follows:

> **Medicare Disproportionate Share Reimbursement**
>
> Whether the Intermediary's adjustment to the disproportionate share hospital (DSH) payments to include CMS' published Medicare/ Social Security Income (SSI) days is appropriate and in accordance with Medicare regulations as set forth in 42 CFR § 412.106?
>
> The Intermediary adjusted the SSI percentages to published SSI tables.
>
> Section 1886(d)(5)(F) of the Social Security Act provides for the additional payments to subsection (d) hospitals that serve a disproportionate share of low income patients. The most commonly used method for a hospital to qualify for the Medicare [DSH] payment adjustment is based on a complex statutory formula under which payment adjustments are based on the hospital's DSH patient percentage, which is the sum of two fractions (expressed as a percentage): the "Medicare fraction" and the "Medicaid fraction."
>
> The Medicare fraction is computed by dividing the number of patient days that were made up of patients who were entitled to both Medicare Part A benefits and [SSI] benefits under Title XVI

[1] Providers' EJR Request at 2-3.
[2] The group appeal request also included 2 other providers with fiscal years ending in 2006 and the Board established a separate 2006 CIRP for these other 2 providers. Board Notice Dated April 15, 2013.

of the Act (the numerator of the Medicare fraction) by the total number of patient days that were made up of patients entitled to benefits under Medicare Part A (the denominator of the fraction). In order to calculate the numerator of the Medicare fraction, CMS obtains a data file from the Social Security Administration that include a list of eligible SSI recipients (the SSI file). CMS then matches information from this SSI file against its own Medicare Part A entitlement information to determine the number of Medicare/SSI days for a particular hospital in a particular fiscal year. The denominator of the Medicare fraction is calculated by CMS based on the Medicare claims data. CMS then posts the Medicare fraction for each DSH hospital in the CMS website under the SSI/Medicare Part A Disproportionate Share Percentage File.

The Providers have a good faith belief that CMS understated the Providers' number of patient days furnished to patients that were entitled to both Medicare Part A benefits and SSI benefits when calculating the Providers' Medicare fraction (and resulting DSH patient percentage and DSH payment adjustment) for the cost reporting period at issue.

The Providers also believe that Medicare/Medicaid dual eligible patient days when benefits are exhausted and Medicare Advantage patient days covered under Medicare Part C *should appropriately be excluded from the Medicare (SSI) proxy and instead be included in the Medicaid proxy (assuming documentation proving Medicaid eligibility)*. The current treatment for these days is to include the days in the Medicare (SSI) proxy and exclude them from the Medicaid fraction. *The below explanation expands on these issues.*

SSI Days
The Provider believes that SSI days are understated by at least 10,000. We are currently taking steps to analyze and more precisely determine the impact.

Amount in controversy: $10,000

Medicare/Medicaid Dual Eligible Days
Some patients are enrolled in both the Medicare and Medicaid programs. The key to determining whether these days were for dual enrollees should be included in the Medicaid SSI fraction is the meaning of the term "entitled to benefits under PT A." *The provider community contends that the Medicare/Medicaid dual eligible patient days should be <u>included</u> in the Medicaid fraction when Part A benefits are exhausted because these days are attributable to*

patients who were "eligible" for Medicaid benefits although not "entitled" to inpatient Medicare Part A hospital benefits. The current treatment of these days is to include these days in the Medicare (SSI) proxy and exclude them from the Medicaid fraction.

The basis for the providers' position is rooted in how the courts have previously differentiated the terms "entitlement" versus "eligibility." Despite positions held by CMS, the courts deliberated that Congress' distinct usage of these different terms in the same sentence implied Congress' intention of the two different meanings. Moreover, before acquiescing on the Medicaid "eligibility" issues in the late 1990s, CMS openly defined "entitlement" as meaning actual payment, and accordingly, directed contractors to audit claimed DSH days by requiring verification of Title XIX paid logs. The courts accepted CMS' definition of "entitlement" as meaning payment, but more meaningfully, deliberated that the plain meaning of eligibility does not require proof of payment. For a period of time, these definitions went unchallenged. Both providers and intermediaries applied the recently re-defined logic to the Medicare exhausted benefit day issues, as well. *In other words, because these exhausted benefit claims were not covered or paid by the Medicare part A benefit, they were not deemed "entitled" to Medicare Part A benefits and, as such, would be excluded from the Medicare (SSI) proxy and instead be included in the Medicaid proxy (assuming documentation proving Medicaid eligibility).*

In summary, CMS' long-held definition of "entitlement" was accepted by the courts, contractors and the provider community as being synonymous with paid days. After realizing the costly financial impact of this interpretation to the Medicare Part A trust fund, CMS reversed its position reconstituting its position that entitlement would once again be synonymous with eligibility. Only this time, rather than asserting eligibility would be defined synonymously with entitlement or proof of payment it asserted that entitlement would be defined as "eligibility" and thus no longer requiring proof of payment.

Amount in controversy: $10,000

Medicare Advantage Days
CMS has adopted the position that Medicare beneficiaries who have elected to receive Medicare benefits under Medicare Part A. Based on the literal wording of the statute, the provider community contends that Medicare Advantage days covered under Medicare

> Part C should be excluded from the Medicare (SSI proxy) and instead included in the numerator of the Medicaid fraction to the extent that the patient is eligible for Medicaid. This position asserts that Medicare Part C is uniquely distinct from Medicare Part A.
>
> Amount in controversy: $10,000[3]

This group issue statement included 3 distinct areas from which 5 issues were identified: (1) SSI data matching process; (2) dual eligible exhausted days where the providers sought to exclude such days from the SSI fraction *and* include them in the Medicaid fraction; and (3) Medicare Part C days where the providers sought to exclude such days from the SSI fraction *and* include them in the Medicaid fraction.

Accordingly, shortly thereafter, on April 25, 2013, the Board notified McGladrey that the group appeal request included five distinct issues and bifurcated the appeal:

> [A]lthough this case was initially filed as a single group appeal (DSH: Medicare SSI Days), there are five distinct issues that must be set up as separate group appeals to meet the requirements of 42 C.F.R. § 408.1837(a)(2). The Board has bifurcated the case into five separate group appeals to cover the five distinct legal questions you described in your initial hearing request. You will receive separate email acknowledgements for the other cases shortly.

These five cases were as follows:

1. *SSI data matching issues*:
   - Case No. 13-1742GC – Good Shepherd Health System 2007 DSH SSI Fraction Baystate Errors CIRP Group

2. *Dual Eligible Exhausted Days*:
   - Case No. 13-1682GC – Good Shepherd Health System 2007 DSH SSI Fraction Dual Eligible CIRP Group
   - Case No. 13-1746GC – Good Shepherd Health System 2007 DSH Medicaid Fraction Dual Eligible CIRP Group

3. *Part C Days*
   - Case No. 13-1741GC – Good Shepherd Health System 2007 DSH SSI Fraction Part C Days CIRP Group
   - Case No. 13-1748GC – Good Shepherd Health System 2007 DSH Medicaid Fraction Part C Days CIRP Group

[3] (Italics and underline emphasis added.)

Accordingly, based on this break out, it is clear that the subject case *(i.e.*, Case No. 13-1682GC) concerned the ***exclusion*** of dual eligible exhausted days ***from*** *the SSI fraction* based upon the premise that the term "entitlement" to Part A benefits should be limited to payment of benefits.

On May 31, 2016, the Board received notice from Maureen O'Brien Griffin at Hall Render Killian Heath & Lyman, P.C. that she had replaced McGladrey as the Group Representative.

On July 5, 2016, the Board sent notice to the parties that the Providers' preliminary position paper was due by April 1, 2017 and the Medicare Contractor's preliminary position paper was due by June 1, 2017. By letter dated March 27, 2017, Ms. Griffin sent the Medicare Contractor a copy of the Providers' preliminary position paper and, consistent with the Notice's instructions, filed a copy of the cover page to the brief with the Board.

On June 23, 2021, the Providers requested expedited judicial review ("EJR"). On July 2, 2021, the Providers supplemented their EJR request with the schedule of providers, inadvertently omitted.

On July 22, 2021, the Board issued a development letter with the following request:

> The Board has reviewed the jurisdictional documentation submitted with the Schedule of Providers and the Board Case Management and Docketing System for the Providers in this case. The Board notes that Hall Render did not file the original hearing request in this matter and the Board does not have a copy of the preliminary position papers filed in this case enable it to clearly understand the issue appealed and complete its jurisdictional review of this group. ***Within 30 days of this letter's signature date***, the parties must upload into OH CDMS their respective preliminary position papers filed on March 28, 2017 (the Providers) and August 1, 2017 (the MAC).

On July 30, 2021, Ms. Griffin filed a complete copy of the Providers' preliminary position paper dated March 27, 2017. The Provider's preliminary position paper asserts that the issue in the subject group appeal is as follows:

> The days at issue in this group appeals are the days of care furnished by the Hospitals to patients who were eligible for and/or entitled to Medicare Part A and Supplemental Security Income benefits. The issue presented in these appeals is whether the provider's [DSH] reimbursement calculations were understated due to [CMS'] and the Medicare Administrative Contractor's ("MAC's") ***failure to include*** *all patient days for patients who were* ***eligible*** *for and enrolled in the SSI program* ***but may not have received an SSI payment*** *for the month in which they received services from the Providers ("SSI Eligible days") in the*

> *numerator of the Medicare fraction of the DSH percentage*, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[4]

The thrust of the Providers' preliminary position paper is that "[t]he Providers contend that CMS has suppressed their DSH adjustments by contorting the language of the DSH statute to ***exclude*** *SSI* ***Eligible*** *patient days* that should be rightly included in the numerator of the Medicare Fraction of the DSH Formula."[5] More specifically, the Providers state:

> Here, CMS construes the term "entitled to benefits under part A" to broadly encompass not only Medicare exhausted days, but also Medicare Secondary Payer days and Medicare Advantage days as well. The basic rules of statutory construction dictate that CMS's broad interpretation must apply equally to SSI benefits, the other element of the statutory language used to establish the numerator of the Medicare Fraction. *Catholic Health*, 718 F.3d 920-21. Thus, the term "entitled to supplemental security income benefits" under the Medicare Fraction must be read to capture individuals who qualify for SSI benefits, irrespective of whether beneficiaries receive cash payments for the month in which they receive medical services from the Providers. Because these SSI Eligible recipients remained entitled to SSI benefits, they are "eligible individuals" under 42 U.S.C. § 1382, and their days should be included in the DSH calculation. **CMS' categorical <u>omission</u> of these individuals <u>from</u> the Medicare Fraction** thus violates the plain language of the statue and must be rejected under *Chevron* Step One.[6]

<u>The Board's Analysis, Findings of Fact and Conclusions of Law</u>:

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842 (2019). Under the implementing regulations, the Board is required to grant a provider's EJR request if it determines that: (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue (as described in 42 C.F.R. § 405.1840); and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling. Further, 42 C.F.R.§ 405.1842(e)(1) states, in relevant part: "If the Board makes a finding that it has jurisdiction to conduct a hearing on a specific matter at issue in accordance with § 405.1840 . . . then (and only then) it must consider whether it lacks the authority to decide a legal question relevant to the matter at issue." Accordingly, a Board finding of jurisdiction is a *prerequisite* to any review of an EJR request.

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[4] Provider's preliminary position paper at 1 (emphasis added).
[5] *Id.* at 3 (emphasis added).
[6] *Id.* at 12 (emphasis added).

The subject case was established by a group appeal request and the simultaneous direct add of a single provider – Marshall Regional Medical Center ("Marshall"). Pursuant to 42 C.F.R. §405.1837(c) (2013), the request for a Board hearing for a group appeal must include the following content described in paragraph 2:

> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its intermediary or Secretary determination under appeal, including an account of—
>
> (i) *Why* the provider believes Medicare *payment is incorrect* for each disputed item;
>
> (ii) *How **and** why* the provider believes Medicare *payment must be determined differently* for each disputed item; and
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.[7]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time were dated March 1, 2013 and provided the following instruction at Rule 13 on the group issue statement included in a group appeal request:

> **Rule 13 – Common Group Issue**
>
> *The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling*. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific Provider(s) may be presented as representative of all group members. *Refer to Rules 7 and 8 for guidance.*[8]

The referenced Board Rules 7 and 8 (March 1, 2013) stated in pertinent part:

> **Rule 7 – Issue Statement and Claim of Dissatisfaction**

[7] (Emphasis added.)
[8] (Italics emphasis added.)

For each issue under appeal, give a brief summary of the determination being appealed and the basis for dissatisfaction. (*See Rule 8 for special instructions regarding multi-component disputes*.)

7.1 – **NPR or Revised NPR Adjustments**

A. Identification of Issue

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

***

7.2 – Self-Disallowed Items

A. Authority Requires Disallowance

If the Provider claims that the item being appealed was not claimed on the cost report because a regulation, manual, ruling, or some other legal authority predetermined that the item would not be allowed, the following information must be submitted:
• a concise issue statement describing the self-disallowed item
• the reimbursement or payment sought for the item, and
• the authority that predetermined that the claim would be disallowed.

***

Rule 8—Framing Issues for Adjustment Involving Multiple Components

8.1 – General

Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described *as narrowly* as possible using the applicable format outlined in Rule 7. See common examples below.

8.2 – Disproportionate Share Cases (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[9]

Here, it is clear that the subject group was established following bifurcation of the original multi-issue group issue statement. It is clear in that original group issue statement that Marshall, as the original founding provider for the subject group, took the position that "Medicare/Medicaid dual eligible patient days should be ***included*** *in the Medicaid fraction* when Part A benefits are exhausted because these days are attributable to patients who were 'eligible' for Medicaid benefits although ***not*** 'entitled' to inpatient Medicare Part A hospital benefits."[10] Accordingly, Marshall maintained that such dual eligible days should be excluded from the SSI fraction (the issue for Case No. 13-1682GC following bifurcation) and included in the Medicaid fraction (the issue for Case No. 13-1746GC following bifurcation). This is based on the assertion that CMS' policy prior to the FY 2004 IPPS final rule was that Part A entitlement should be interpreted as limited to payment of Part A benefits (which would be consistent with how CMS has interpreted entitled to SSI benefits, *i.e.*, payment of SSI benefits).

In its preliminary position paper and the EJR request, the Providers are now trying to change the issue from ***removing*** certain Dual Eligible days from the SSI fraction to ***adding*** days to the SSI fraction. This results in the Providers changing their legal explanation of why Medicare payment must be determined differently. They are now arguing that "entitled" to Medicare Part A benefits as used in the SSI fraction should be interpreted to mean payment of benefits to those "entitled" to SSI benefits (which they argue is consistent with how CMS began interpreting entitled to Medicare Part A benefits effective with the FY 2004 IPPS final rule). As noted above, 42 C.F.R. § 405.1837(c) specifies that the group appeal request must explain for each issue both "[w]hy the provider believes Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider believes Medicare payment must be determined differently for each disputed item." The Providers are not allowed to later change their appealed issue, the hows and whys.[11] Similarly, 42 C.F.R. § 405.1837(f)(1) prohibits the adding of issues to a group appeal once it is established.[12]

The Board finds that the Providers abandoned the original issue and are improperly trying to change the group issue to a new issue (*i.e.*, they have changed both the explanation of why payment is incorrect and the explanation of how and why payment must be determined differently). They have then requested EJR on this new issue. In this regard, the Providers' preliminary position paper does not brief the original group issue, *i.e.*, the desire to exclude dual eligible exhausted days from the SSI fraction. Board Rule 25 (July 1, 2015)[13] required the

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[9] Board Rule 8 (March 1, 2013 & July 1, 2015) (italics and underline emphasis added).
[10] (Emphasis added.)
[11] The fact that the Group Representative changed between the original group appeal and the filing of the preliminary position paper does not give the Providers license to transform their appeal into a new issue.
[12] 42 C.F.R. 405.1837(f)(1) states: "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may not add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal (as described in §405.1837(a)(2) and (g) of this subpart)." (Emphasis added.)
[13] These were the Board Rules in effect when the Providers filed their preliminary position paper.

Providers to present fully-developed positions[14] and the Providers failed to brief the issue appealed as required under Board Rules.[15]

Based on the above findings, the Board hereby dismisses Case No. 13-1682GC and denies the Providers' EJR request. 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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Robert A. Evarts, Esq.
Susan A. Turner, Esq.
Kevin D. Smith, CPA

For the Board:

8/27/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Bill Tisdale, Novitas Solutions

[14] The Commentary to Board Rule 25 states: "preliminary position papers now are expected to present ***fully developed*** positions of the parties and, therefore, require analysis well in advance of the filing deadline." (Emphasis added.) To this end, Board Rule 25.1 specifies that: "1. For each issue, state the material facts that support your claim. 2. Identify the controlling authority . . . 3. Provide a conclusion applying the material facts to the controlling authorities." Finally, the Commentary to Board Rule 23.3 states: "the Board expects preliminary position papers to be fully developed and include all available documentation necessary to give the parties a thorough understanding of their opponent's position."

[15] Indeed, the Board notes that, on or about July 8, 2016, the Providers withdrew Case No. 13-1746GC, the sister case wherein the Providers were seeking to add dual eligible exhausted days to the Medicaid fraction.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Harford Health FFY 2019 Wage Index Malpractice Costs CIRP Group
Case No. 19-1177GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above-referenced common issue related party ("CIRP") group appeal. The Board concludes the CIRP group appeal was *not* timely filed. Consequently, the Board dismisses the CIRP group appeal.

Background

On February 14, 2019, two Providers filed a CIRP Group Appeal Request, challenging the wage index adjustment to, citing the fiscal year ("FY") 2019 inpatient prospective payment system ("IPPS") final rule, 83 Fed. Reg. 41144, 41362 (Aug. 17, 2018). The Board assigned the CIRP group appeal to Case No. 19-1177GC. In their group issue statement, the Providers asserted the following:

> The Medicare Administrative Contractor ("MAC") disallowed the malpractice costs of multiple New York hospitals . . . in calculating the wage index for FY 2019. The Centers for Medicare and Medicaid Services affirmed the disallowance of the Excluded Hospitals' malpractice costs, thereby lowering the wage index adjustment for the core-based statistical areas . . . in which the Providers in this appeal are situated and reducing their total Medicare reimbursement in FY 2019. CMS's final determination regarding this matter was reflected in the wage indices announced in the FY 2019 IPPS final rule. **83 Fed. Reg. 41144, 41362 (Aug. 17, 2018)**. This appeal is filed **from <u>that</u> rulemaking**. *Id*.[1]

[1] Providers' February 14, 2019 Appeal Request, Group Issue Statement at 1 (emphasis added.

Accordingly, this statement represented that the Providers were appealing from the rulemaking published in the Federal Register on August 17, 2018 which is the FY 2019 IPPS Final Rule, 83 Fed. Reg. 41144 (Aug. 17, 2018).

Notwithstanding, other aspects appeal request make it clear that the Provider appealed from the FY 2019 IPPS Correction Notice, 83 Fed. Reg. 49836 (Oct. 3, 2018) ("FY 2019 Correction Notice"). First, the cover letter included with the appeal makes it clear that the Provider appealed from the FY 2019 Correction Notice or, *in the alternative*, from the FY 2019 IPPS Final Rule based on a good cause exception under 42 C.F.R. § 405.1836:

> The Providers hereby file the above-referenced group appeal from the notice of correction to the FY 2019 IPPS final rulemaking. 83 Fed. Reg. 49836, 49839-41 (Oct. 3, 2018). The Providers are challenging the calculation of the sage index for FY 2019. Since the correction notice issued on October 3, 2018 made changes to the FY 2019 wage index, it is appropriate for the Providers to appeal from that determination. It is a bedrock principle of Medicare reimbursement that whenever an issue is addressed in a revised determination, the provider may appeal that issue from the revised determination. CMS's revised wage index determination in its correction notice has the potential to attach new legal consequences to the wage index that was originally published with the final rule. Finally, the revised wage index determination may have concerned the treatment of medical malpractice costs in the wage index.
>
> ***In the alternative****, if the Board will not allow the Providers to appeal the 2019 wage index from the notice of correction to the FY 2019 IPPS final rulemaking, the Providers hereby apply for a good cause exception to file their appeal from the FY 2019 IPPS rulemaking*. These circumstances warrant a good cause extension because the punishment of dismissing the appeal would far outweigh the harm. No parties have been prejudiced by the *Providers' less than 24-hour delay in filing its appeal*. Furthermore, good cause is warranted because the Providers were confused by the October 3 2018 amendment.[2]

To this end, in the Office of Hearings Case Document Management System ("OH CDMS") the Providers identified the FY 2019 Correction Notice, as the final determination from which they were appealing. Further, (consistent with their obligation under 42 C.F.R. § 405.1837(c)(3) to attach a copy of the determination being appealed), the Providers provided with the CIRP group

[2] (Emphasis added.)

appeal request a copy of the FY 2019 Correction Notice as well as a copy of the FY 2019 IPPS Final Rule for the Board.

On April 26, 2019, the Medicare Contractor submitted a 30-day letter to the Board advising the Board that the group in Case No. 19-1177GC had appealed a single common issue; however, the Providers had failed to meet the 180 days requirement from a final determination date (August 17, 2018) to the original appeal request receipt date (February 14, 2019) (181 days late) for an appeal based off of a Federal Register determination.[3]

On May 28, 2019, the Providers responded to the Medicare Contractor's 30-day letter. The Providers asserted that it *cited* in its appeal both the Original Rulemaking issued on August 17, 2018 as well as the Corrected Notice of Rulemaking issued on October 3, 2018, 83 Fed. Reg. 49836 (Oct. 3, 2018). The Providers contend that, in the *Corrected* Rulemaking, CMS made changes to the wage index for FY 2019. The Providers maintain that these changes affected the wage index values for both of the hospitals in the group appeal. The Providers assert that the wage index values for both hospitals changed from 1.3338 in the Original Rulemaking to 1.3348 in the Correction Notice (citing to Table 2 of the Original and Corrected Rulemakings). Therefore, the Providers argue that they are entitled to file an appeal from the Corrected Rulemaking issued on October 3, 2018; the group appeal was timely filed 134 days after the Corrected Rulemaking.[4]

On March 24, 2021, the Board sent the Providers a Request for Information. The Board advised the Providers that additional information was needed regarding the Providers' contention that they appealed from both the Original Federal Register Rulemaking and the 2019 IPPS Correction Notice. The Board asked the Providers to answer the following questions and provide the requested information:

1. The Providers' February 14, 2019 Group Issue Statement states: "CMS's final determination regarding this matter was reflected in the wage indices announced in the FY 2019 IPPS final rule. 83 Fed. Reg. 41144, 41362 (Aug. 17, 2018). This appeal is filed from that rulemaking." Please advise how this statement is congruous with the Providers' claim that they are appealing from both the Original Federal Register Rulemaking and the 2019 IPPS Correction Notice.

2. The group appealed "the disallowance of the Excluded Hospitals' malpractice costs." Confirm whether this disallowance occurred in the August 17, 2018 rulemaking or the October 3, 2018 rulemaking. Similarly, advise the Board in which Federal Register notice- the Original Federal Register Rulemaking or the 2019 IPPS Correction Notice- the audit adjustment disallowances being appealed were included.

[3] Medicare Contractor's April 26, 2019 30-day Response Letter at 1.
[4] Providers' May 28, 2019 Response to 30-day letter at 1.

3. Provide the Board with the Medicare Contractor's dated Audit Adjustments to the wage index malpractice costs and advise the Board the date on which the published values used to make the audit adjustments were published.

4. Whether the October 3, 2018 "Correction" rulemaking, for purposes of appeal rights, is a revised "Secretary determination" and, in this regard, whether any appeal rights to a Board hearing on the October 3, 2018 rulemaking are derived from (and thereby subject to) 42 C.F.R. § 405.1889.[5]

The Board requested a response from the Providers within 30 days of the date of the letter.[6]

On April 23, 2021, the Providers' Representative responded to the Board's Request for Information. In response to Board Question 1, the Providers maintain that they are appealing the ***policy*** *that was adopted in the FY 2019 IPPS final rule* insofar as that policy continued to be reflected in the wage index values that were published with the notice of correction to the FY 2019 IPPS final rulemaking. The Providers assert the policy was *first implemented in the final rule* but it was applied again when CMS made corrections to the wage index in the notice of correction.[7] The Providers maintain while the issue statement used was a template and did not reference the correction notice, it identified the correction notice as the final determination under appeal by both citing the correction notice in the Federal Register Citation field in OHCDMS and uploading that document as the Final Determination Document; it also explained in the document titled other issue Document-1 that they were filing the appeal "from the notice of correction to the FY 2019 IPPS final rulemaking" on the basis that "the correction notice made changes to the FY 2019 wage index. . . ." The Providers assert recognizing that appeals from a correction notice are not typical, it asks the Board to grant a *good cause* extension of a single day in the event the Board holds that this appeal needed to flow from only the 2019 IPPS final rule.[8]

In response to Board Question 2, the Providers maintain the malpractice costs of excluded hospitals were originally excluded from the calculation of the wage index values that were published with the final rule dated August 17, 2018. However, the malpractice costs were excluded again when CMS recalculated the wage index for the correction notice dated October 3, 2018. The Providers maintain CMS explained in the correction notice that the agency had to recalculate the wage index values for hospitals nationwide because it had identified errors in the wage data that was used to calculate the wage index values in the final rule. The Providers assert it is appealing CMS' exclusion of the malpractice costs of the excluded hospitals from the recalculation of the wage index that occurred in the correction notice dated October 3, 2018. The Providers maintain the audit adjustments were originally included and applied in the final rule dated August 17, 2018. However, they were applied again when the wage index was recalculated in the correction notice dated October 3, 2018.[9]

[5] Board's March 24, 2021 Request for Information at 3.
[6] *Id.* at 4.
[7] Providers' April 23, 2021 Response to Board's Request for Information at 1.
[8] *Id.* at 2.
[9] *Id.* at 2-3.

In response to Board Question 3, the Providers assert that they have attached as Exhibits P-1 and P-2 the work papers from the Medicare Contractor's audit of the wage and hour data for Montefiore Health and Northwell Health (Providers not listed on the Schedule of Providers). The other excluded hospitals are operated by NYC H+H System. The Providers maintain since the NYC H+H Health System has not appealed this issue, it is not able to produce the Medicare Contractor's work papers or adjustments for the hospitals in that system.[10]

In response to Board Question 4, the Providers maintain that the correction notice dated October 3, 2018, is an *original* final Secretary determination. The Providers argue their appeal rights are predicated on 42 C.F.R. § 405.1837, which entitles providers a right to a Board hearing as part of a group appeal with other providers with respect to a final contractor or Secretary determination. The Providers assert the correction notice dated October 3, 2018 is ***not*** a revision as described in 42 C.F.R. § 405.1889.[11] In support, they assert that it cannot be a revised determination because CMS did not comply with the mandatory procedures of a revised determination prescribed in § 405.1887. The Providers maintain that affected parties were not afforded any opportunity to respond to the correction notice. CMS posted the notice of correction without soliciting any comments. The Providers assert that, even if the correction notice were a revised determination (it is not), the Providers are still entitled to a hearing as CMS recalculated all wage index values in the correction notice. The wage index was specifically adjusted. The Providers maintain that by adjusting the wage index calculation, CMS has opened the entire wage index calculation to appeal.[12, 13]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Secretary or 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 Federal Register notice is the Secretary's final notice of the IPPS rates for each Federal fiscal year. The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[14] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically

[10] *Id.* at 3.
[11] *Id.*
[12] Citing to *Beverly Hospital*, Case No. 04-1083 (PRRB finding that uncompensated care pool days, Medicare Choice days, and the SSI percentage issues are components of a single DSH calculation and the Board has jurisdiction over all three where the revised NPR reflected an adjustment to the DSH calculation); *Blessing/St. Mary GME Group Appeal*, PRRB Dec. No. 97-D57; HCFA Adm'r Dec., reprinted in Medicare & Medicaid Guide (CCH) ¶ 45,554, at 54,788 (July 7, 1997) (Board and Administrator upholding Board jurisdiction to consider certain GME costs notwithstanding the absence of an audit adjustment on that particular aspect of GME reimbursement).
[13] Providers' Response to Request for Information at 4.
[14] *See* 42 C.F.R. § 405.1867.

with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[15] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[16] of the Social Security Act [relating to disclosure of information] as it applies to [CMS]. . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[17] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
>
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System (PPS) rates in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[18]

With regard to the notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give*

[15] of the Department of Health and Human Services.
[16] 42 U.S.C. § 1306(a).
[17] 5 U.S.C. § 550 *et seq*. contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act (FOIA).
[18] *See also* 42 C.F.R. Part 401, Subpart B.

> *notice* of the contents of the document to a person subject to or affected by it (emphasis added).

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office (GPO) promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet on the GPO website.[19] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[20] Consequently, the Provider is deemed to have notice of the wage index on the date the Federal Register was published and made available online.

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[21]

In this case, the Providers' appeal was received[22] in the Board's office on February 14, 2019, 181 days after the publication of the August 17, 2018 Federal Register, 83 Fed. Reg. 41144, 41362.[23] In the cover letter attached to their CIRP group appeal request, the Providers appealed based on the FY 2019 Correction Notice. The Providers further conceded that their appeal request would be considered a day late if it were appealing from the FY 2019 IPPS Final Rule and, accordingly, included a good cause exception under 42 C.F.R. § 405.1836 for the late filing in the event the Board found that it was improper to appeal from the FY 2019 Correction Notice.

The Providers maintain that it was proper to appeal from the FY 2019 Correction Notice based on its assertion the FY 2019 Correction Notice made changes to the wage index for FY 2019. Therefore, they argue they are entitled to file an appeal from the FY 2019 Correction Notice

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[19] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[20] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[21] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[22] The date of receipt is presumed to be the date of delivery. 42 C.F.R. § 405.1801(a)(2)(i) (2019). A provider has the right to a Board hearing if the date of receipt of the provider's hearing request is not later than 180 days after the date of receipt of the final contractor or Secretary's determination. 42 C.F.R. § 405.1835(a)(3)(2019). *But see* 42 U.S.C. § 1395oo(a)(3) which requires an appeal be filed "within 180 days of the Secretary's notice." The publication of the Inpatient Prospective Payment System Rules in the Federal Register constitutes the Secretary's notice of the rates for the upcoming Federal fiscal year.
[23] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

issued on October 3, 2018; their group appeal was timely filed 134 days after the FY 2019 Correction Notice.[24]

The Board finds that the Providers improperly appealed the malpractice issue from the FY 2019 Correction Notice. The Board finds the FY 2019 Correction Notice only revised the wage index values to account for "three hospitals (CCNs 010001, 060016, 100044) as it related to the FY 2019 national average hourly wages unadjusted for occupational mix and adjusted for occupational mix. Accordingly, it is clear that the update in the FFY 2019 wage index related only to occupation mix error and did ***not*** relate the malpractice issue appealed by the Providers. In this regard, the Providers recognize that the policy that they are appealing was ***first*** implemented in the FY 2019 IPPS Final Rule (as opposed to the Correction Notice) by stating:

> *The Providers are appealing the policy that was adopted in the FY 2019 IPPS final rule* insofar as that policy continued to be reflected in the wage index values that were published with the notice of correction to the FY 2019 IPPS final rulemaking. 83 Fed. Reg. 49836, 49839-41 (Oct. 3, 2018). *The **policy** was first implemented in the final rule* but it was applied again when CMS made corrections to the wage index in the notice of correction.
>
> ***
>
> The malpractice costs of the Excluded Hospitals were *originally excluded* from the calculation of the wage index values that were published with the final rule dated August 17, 2018.

Moreover, the following excerpt from the Correction Notice confirms that the Correction Notice only related to "technical and typographical errors" and are effective "as if they had been included" in the August 17, 2018 publication of the FY 2019 IPPS Final Rule:

> **SUMMARY:** This document *corrects technical and typographical errors* in the final rule that appeared in the August 17, 2018 issue of the **Federal Register** titled ''Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System and Policy Changes and Fiscal Year 2019 Rates; Quality Reporting Requirements for Specific Providers; Medicare and Medicaid Electronic Health Record (EHR) Incentive Programs (Promoting Interoperability Programs) Requirements for Eligible Hospitals, Critical Access Hospitals, and Eligible Professionals; Medicare Cost Reporting Requirements; and Physician Certification and Recertification of Claims''.

[24] Providers' May 28, 2019 Response to 30-day letter at 1.

> **DATES**: The corrections in this document are effective October 1, 2018.
>
> ***
> In FR Doc. 2018–16766 of August 17, 2018 (83 FR 41144) there were a number of *technical and typographical errors* that are identified and corrected by the Correction of Errors section of this correcting document. *The provisions in this correcting document are effective as if they had been included in the document that appeared in the August 17, 2018 Federal Register*. Accordingly, the corrections are effective October 1, 2018.[25]

Accordingly, by the very terms of the Correction Notice, any corrections or changes made therein are as if they were included in the FY 2019 IPPS Final Rule published on August 17, 2018. Accordingly, the Board must conclude that ***no*** appeals flow from the FY 2019 Correction Notice. Rather, any appeal rights that the Provider may have as they may relate to the "technical and typographical errors" corrected in the FY 2019 Correction Notice would have had to have been appealed based on the FY 2019 IPPS Final Rule (*i.e.*, 180 days from the publication of the FY 2019 IPPS Final Rule on August 17, 2018) since such "technical and typographical errors" were corrected as if they had been included in the FY 2019 IPPS Final Rule.

Similarly, the Board must reject the Providers' argument that the FY 2019 Correction Notice is somehow an original "final Secretary determination." Again, by the very terms of the FY 2019 Correction Notice, the corrections made therein are considered as if they were part of the original determination published on August 17, 2017 in the FY 2019 IPPS Final Rule. As such, the FY 2019 Correction Notice by its own terms cannot be considered an original "final Secretary determination" (or even a revised determination[26]) from which appeal rights flow.

In the alternative, the Board finds that, if the Board were to treat the Providers appeal as if it were based on the FY 2019 IPPS Final Rule published on August 17, 2018, then the Board must find that the appeal was not timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which requires an appeal be filed "*within 180 days after notice of the . . .Secretary's final determination.*"[27] This appeal was received in the Board's offices 181 days after the issuance of the August 17, 2018 Federal Register giving notice of the inpatient prospective payment rates for FFY 2019. As noted above, the Board finds that the August 17, 2018 Federal Register is the correct Federal Register from which the Providers should have appealed.

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[25] (Italics and underline emphasis added.)
[26] Had the Board determined that the FY 2019 Correction notice was a revised determination under 42 C.F.R. § 405.1889, it is clear that 42 C.F.R. § 405.1889 as it specifically refers to "Secretary Determination." However, the Correction Notice does not *specifically* revise the wage index relative to the malpractice issue appealed and any appeal rights would be precluded under 42 C.F.R. § 405.1889(b).
[27] (emphasis added).

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act (APA)) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the IPPS rules. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office. Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents. As a result, the Providers did not file the hearing request within 180 days of the publication of the Federal Register notice and the Board concludes the appeal was not timely.

The Providers have conceded this untimeliness and specifically requested that the Board to grant a good cause extension in the event the Board holds that this appeal needed to flow from the FY 2019 IPPS Final Rule. The Providers assert that the circumstances warrant a good cause extension because:

1. The punishment of dismissing the appeal would far outweigh the harm; and

2. No parties have been prejudiced by the Providers' less than 24-hour delay in filing its appeal. Furthermore, good cause is warranted because the Providers were confused by the October 3, 2018 amendment.[28]

Pursuant to 42 C.F.R. § 405.1836(b), "[t]he Board may find good cause to extend the time limit only if the provider demonstrates in writing it could not reasonably be expected to file timely due to extraordinary circumstances beyond its control (such as natural or other catastrophe, fire, or strike), and the provider's written request for an extension is received by the Board within a reasonable time . . . ." The Board finds the Providers' circumstances do not fall under any of these categories and that the very terms of the FY 2019 Correction Notice demonstrates that the Providers alleged confusion has no basis. Accordingly, the Board denies the Providers request for a good cause extension of the time limit because they do not qualify for one under 42 C.F.R. § 405.1836(b).

In summary, the Board finds that no appeal rights flowed directly from the FY 2019 Correction Notice (i.e., the Providers could not appeal from the FY 2019 Correction Notice). Rather, the Providers were required to appeal the malpractice issue based on the FY 2019 IPPS Final Rule published on August 17, 2018. However, the Providers' appeal request based on the FY 2019 IPPS Final Rule was untimely and the Providers failed to establish good cause under 42 C.F.R. § 405.1836(b) to warrant the Board granting an extension. Accordingly, the Board hereby dismisses Case No. 19-1177GC and removes it from the Board's docket.

[28] Providers' Other Issue Document-1 February 14, 2019 Letter at 1.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

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

FOR THE BOARD:

8/30/2021

X Clayton J. Nix

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

cc: Danelle Decker, National Government Services, Inc.
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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James Ravindran &
Janahan Ramanathan
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RE: ***Dismissal For Failure to Comply with Board Order***
18 QRS Group Appeals Involving FFY 2020 ATRA IPPS Payment Reduction
Case Nos. 20-0370GC, *et. al* (*see* Appendix A for complete listing)

Dear Mr. Ravindran and Mr. Ramanathan,

The Provider Reimbursement Review Board ("PRRB or Board") has reviewed the 18 group appeals listed on Appendix A. The Board dismisses the above-referenced appeals for failing to respond to the Board's Request for Status Update and Notice of Potential Own Motion EJR.

Background

On August 2, 2021, the Board sent correspondence to the Providers in the above-referenced appeals requesting a status update and comments regarding a potential own motion Expedited Judicial Review ("EJR"). The Board advised the Providers:

> ***Within fifteen (15) days of this letter's signature date***, the Representatives must file a response that:
>
> 1. Provides a status update and confirms whether the underlying providers remain committed to pursuing the case; and
>
> 2. If the case is not being pursued, requests withdrawal.
>
> *If the Representative's filing identifies that the case will remain open, then* ***within thirty (30) days of this letter's signature date***:
>
> 1. The parties must file comments on whether EJR is appropriate for the issue under appeal in this case pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842; and
>
> 2. The Representatives must file the final Schedule of Providers with supporting documentation *to the extent* one has not already been filed in the case.

> *These filing dates are firm and the Board has determined to exempt them from Board Alert 19 suspension of Board-set deadlines. Failure of the representatives to timely respond to the first request may result in dismissal and failure of the parties to timely respond to the second request may result in Board action without the benefit of the parties filing.*[1]

Decision of the Board

Board Rule 1.1. states that the Board Rules "govern proceedings before the [Board]" and that "[t]he Board has discretion to take action as outlined in 42 C.F.R. § 405.1868 if a party fails to comply with these rules or fails to comply with a Board order." 42 C.F.R. § 405.1868(a)(b) provides:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions *in response to the failure of a party to a Board appeal to comply with Board rules and orders* . . . .
>
> (b) *If a provider fails to meet a filing deadline* or other requirement established by the Board in a rule or order, the Board may-
>
> (1) *Dismiss the appeal with prejudice*;
>
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
>
> (3) Take any other remedial action it considers appropriate.[2]

Board Rule 9 entitled "Board Acknowledgment of Appeals" provides: "[t]he acknowledgement and subsequent correspondence will establish various deadlines and due dates. Failure by a party to comply with such deadlines . . . may result in the Board taking any of the actions described in 42 C.F.R § 405.1868."

Finally, Board Rule 41.2 provides:

> [t]he Board may . . . dismiss a case or an issue on its own motion:
>
> - *If it has a reasonable basis to believe that the issues have been* fully settled or *abandoned*,

[1] (Emphasis in original.)
[2] (Emphasis added.)

- *upon failure of the provider or group to comply with Board procedures* (see 42 C.F.R. § 405.1868),
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.[3]

In the Board's August 2rd 2021 Request for Status Update and Notice of Potential Own Motion EJR letter, the Board advised the Providers in the above-referenced appeals that they were ***required*** to file a response with the Board providing a status update and confirming whether they remained committed to pursuing their cases within 15 days of the letter's signature date. The notice specifically exempted the filing from the Board Alert 19 suspension of Board set deadlines and advised the Providers that failure to timely provide the requisite status report "may result in dismissal." The Providers' status report was due to the Board on August 17, 2021. The Board did not receive a response from the Providers by the deadline date (nor had any correspondence been received since that date).

As previously noted, the Board's letter advised the Providers that failure of their representatives to timely respond to the Board's Request for Status Update may result in dismissal. Pursuant to 42 C.F.R. § 405.1868(b), and the Board Rules (see, e.g., Board Rules 1.1, 9 and 41.2), the Board may dismiss a case if a provider fails to meet a filing deadline. Because the Providers' Representatives did not timely file a response with the Board providing a status update and confirming whether they remain committed to pursuing their case by the Board's August 17th deadline date the Board hereby dismisses the above-referenced appeals and closes the cases.

Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating

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Robert A. Evarts, Esq.
Susan Turner, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

8/30/2021

X Clayton J. Nix

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

[3] (Emphasis added.)

cc: Geoff Pike, First Coast Service Options, Inc.
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS Government Health Administrators
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
John Bloom, Noridian Healthcare Solutions
Bruce Snyder, Novitas Solutions, Inc.
Bill Tisdale, Novitas Solutions, Inc.
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danelle Decker, National Government Services, Inc.
Wilson Leong, Federal Specialized Services

APPENDIX A

Case No. 20-0370GC, Baycare Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0371GC, Wellstar Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0372GC, BJR Healthcare FFY 2020 ATRA IPPS Payment Reduction
Case No. 20-0383GC, Cape Fear Valley Health FFY 2020 ATRA IPPS Payment Reduction
Case No. 20-0384GC, Multicare Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0385GC, Novant Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0386GC, Skagit Regional Health FFY 2020 IPPS Payment Reduction CIRP
Case No. 20-0387GC, Univ of Washington Med CY 2020 ATRA IPPS Payment Reduction
Case No. 20-0401GC, St. Luke's University FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0419G, QRS FFY 2020 ATRA IPPS Payment Reduction Group
Case No. 20-0469GC, Banner Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0520GC, BS&W Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0521GC, Quorum Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0525GC, Houston Methodist FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0647GC, AHMC Healthcare FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0648GC, Western CT Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0728GC, St. Luke's Health FFY 2020 ATRA IPPS Payment Reduction CIRP
Case No. 20-0729GC, WVU Medicine FFY 2020 ATRA IPPS Payment Reduction CIRP

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: B1-01-31
Baltimore, MD 21244-1850
410-786-2671

Via Electronic Delivery

Erin Feilmeier
Director of Quality Management
Mercy Rehabilitation Hospital Clive
1401 Campus Dr.
Clive, IA 50325

RE: ***Notice of Dismissal***
Mercy Rehabilitation Hospital Clive (Prov. No. 16-3025)
FFY 2018
Case No. 20-0736

Dear Ms. Feilmeier:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Mercy Rehabilitation Hospital Clive's ("Provider") Individual Appeal Request on January 27, 2020. On January 29, The Board issued an Acknowledgement and Critical Due Dates letter which set forth briefing deadlines, including Provider's Preliminary Position Paper, which was due September 23, 2020.

On March 25, 2020, the Board issued Alert 19, which indefinitely suspended "Board-Set Deadlines" from Friday, March 13, 2020 forward. On September 29, 2020, a Notice of Hearing was issued to the parties which required the Provider file its Final Position Paper by May 5, 2021, and also set a hearing for August 3, 2021. Following the due date of Provider's Final Position Paper, Board staff have attempted to contact the Provider's Representative to inquire as to whether the Provider was still pursuing the appeal on three (3) separate occasions. To date, the Provider has not responded to any of these inquiries.

On August 10, 2021, the Board issued a letter notifying the Provider that, based on the lack of responsiveness from the Provider's Representative, it was formally requesting a response with regard to whether the Provider is still pursuing this appeal. The Board required the response within fifteen (15) days of the letter, noting that the filing deadline was specifically exempt from Board Alert 19's suspension of filing deadlines. The Board further noted that the "***[f]ailure of the Provider*** *to respond by the above filing deadline* ***will*** *result in the dismissal of this case*." The deadline has passed and the Provider has not filed a response to the Board's letter.

Board Rule 41.2 (Aug. 29, 2018) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,

- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

The regulations governing position papers can be found at 42 C.F.R. § 405.1853:

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. In each case, and as appropriate, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board.
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

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

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Based on the lack of response from the Provider and its failure to comply with the Board's filing deadline set forth in its August 10, 2021 letter, the Board hereby dismisses this case and removes it from its docket.

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

Board Members:

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

For the Board:

8/30/2021

X Clayton J. Nix

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

cc: Bianca Smith, Esq. Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators