



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Community Health Systems
Nathan Summar
4000 Meridian Boulevard
Franklin, TN 37067

Wisconsin Physician Services
Byron Lamprecht
Cost Report Appeals
2525 N 117th Avenue, Suite 200
Omaha, NE 68164

RE: Merit Health Gilmore Hospital
Provider No. 25-0025
FYE 12/31/2014
PRRB Case No. 17-1589

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Board (Board) has reviewed the jurisdictional documents in the above-referenced appeal. The jurisdictional decision of the Board is set forth below.

Background

Merit Health Northwest Mississippi is appealing the amount of Medicare Reimbursement as determined by its Medicare Contractor in an Original Notice of Program Reimbursement (NPR) dated December 2, 2016. The Provider timely filed an appeal from the NPR on May 26, 2017. The Model Form A- Individual Appeal Request presented eleven issues:

1. DSH Payment Supplemental Security income (SSI) Percentage (Provider Specific)
2. DSH /SSI (Systemic Errors)
3. DSH SSI Fraction/ Medicare Managed Care Part C Days
4. DSH SSI Fraction/ Dual Eligible Days
5. DSH Medicaid Fraction/ Medicare Managed Care Part C Days
6. DSH Medicaid Fraction/ Dual Eligible Days
7. DSH Medicaid Eligible Days
8. DSH Medicare Managed Care Part C Days
9. DSH Dual Eligible Days
10. Uncompensated Care ("UCC") Distribution Pool
11. 2 Midnight Census IPPS Payment Reduction.

On January 31, 2018 the Board received transfer requests from the Provider for the following issues:

- Issue 2: Supplemental Security Income Percentage, PRRB CN: 17-0578GC;
- Issue 3: SSI Fraction/Medicare Managed Care Part C Days. PRRB CN: 17-0576GC;

- Issue 4: DSH SSI Fraction/ Dual Eligible Days, PRRB CN: 17-0575GC;
- Issues 5 & 8: Medicaid Fraction/ Medicare Managed Care Part C Days, PRRB CN:17-0574GC;
- Issues 6 & 9: Medicaid Fraction/ Dual Eligible Days Group, PRRB CN: 17-0577GC;
- Issue 10: Uncompensated Care (“UCC”) Distribution Pool, PRRB CN: 17-0573;
- Issue 11: 2 Midnight Census IPPS Payment Reduction, PRRB CN: 17-0572GC.

Two issues remain pending: the SSI Provider Specific and Medicaid Eligible Days issues.

Medicare Contractor Contentions

The Medicare Contractor has challenged jurisdiction over 5 issues: SSI Provider Specific; Medicaid Eligible Days; Medicare Managed Care Part C Days; Dual Eligible Days; and UCC Distribution Pool.

SSI Provider Specific

The Medicare Contractor argues that the Board does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic Errors issue and is an issue that is suitable for reopening, but it is not an appealable issue.¹ The Medicare Contractor goes on to explain that in the context of an SSI realignment request, it has not made a final determination with which a Provider could be dissatisfied, therefore the Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1835. The Medicare Contractor concludes that the Provider cannot appeal the realignment of its SSI percentage or try to leverage its appeal regarding the validity of the SSI percentage by including the realignment as an appeal issue.²

Medicaid Eligible Days

The Medicare Contractor argues that adjustments 22, 28 and 29, to which the Provider cited as a source of dissatisfaction, do not render a final determination with respect to additional Medicaid Eligible days. Adjustment 29 updated the SSI ratio and adjustment 22 updates worksheet S-3, part 1 to reflect the Providers PS+R. The Provider also cites to adjustment 28 which removed protested amounts, but eligible days weren't protested on the protest worksheet.³

Medicare Managed Care Part C Days and Dual Eligible Days

The Medicare Contractor contends that Issue 8, Medicare Managed Care Part C Days, is duplicative of Issues 3 and 5, the SSI and Medicaid fraction Part C Days issues. The Medicare Contractor also contends that Issue 9, Dual Eligible days, is duplicative of Issues 4 and 6, the SSI and Medicaid fraction Dual Eligible Days issues.⁴

¹ Medicare Contractor's Jurisdictional Challenge at 2-3.

² *Id.* at 4.

³ *Id.*

⁴ *Id.* at 4-5.

UCC Distribution Pool

The Medicare Contractor also challenged jurisdiction over the uncompensated care issue, however that issue was transferred to a group appeal on January 31, 2018, therefore the issue will not be addressed in this individual appeal.

Provider's Contentions

SSI Provider Specific

The Provider contends that the Medicare Contractor is incorrect when arguing that the DSH/SSI realignment issue is not an appealable issue.⁵ The Provider states that the Provider is addressing not only a realignment of the SSI percentage but also addressing various errors of omission and commission that do not fit into the "systemic errors" category.⁶ Thus, the Provider argues that this is an appealable item because the Medicare Contractor specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year end ("FYE") as a result of its understated SSI percentage.⁷

Further, the Provider asserts that in *Northeast Hospital Corporation v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011), the Centers for Medicare and Medicaid Services ("CMS") abandoned the CMS Administrator's December 1, 2008 decision.⁸ The decision here that was abandoned was that the SSI ratio cannot be revised based upon updated data after it has been calculated by CMS.⁹ Thus, the Provider reasons that it can submit data to prove its SSI percentage was understated.

Medicaid Eligible Days

The Provider argues that the Board has jurisdiction over the Medicaid Eligible Days issue because there was an adjustment to the DSH on its cost report, which is enough to warrant jurisdiction. The Provider also argues that DSH does not have to be adjusted or claimed on a cost report. It also cites to delays in receiving information from the state as a "practical impediment."¹⁰

Medicare Part C and Dual Eligible Days Duplicate Issues

The Provider agrees that there are duplicate issues and requests that Issue 5 be consolidated with Issue 8 and that Issue 6 be consolidated with Issue 9.¹¹

⁵ Provider's Jurisdictional Response at 2.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.* at 3.

¹¹ *Id.* at 12.

Board's Decision

SSI Provider Specific

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the Systemic Errors issue that the Provider transferred to case no. 17-0578GC and is dismissed by the Board.¹² The DSH Payment/SSI Percentage (Provider Specific) issue concerns “whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital Calculation.”¹³ The Provider’s legal basis for its SSI Provider Specific issue also asserts that “the Medicare Contractor did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i).”¹⁴ The Provider argues that “its SSI percentage published by [CMS] was incorrectly computed . . .” and it “. . . specifically disagrees with the MAC’s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary’s Regulations.”¹⁵

The Provider’s Systemic Errors issue is “Whether the Secretary properly calculated the Provider’s Disproportionate Share Hospital/Supplemental Security Income percentage.” Thus, the Provider’s disagreement with how the Medicare Contractor calculated the SSI percentage that would be used for the DSH percentage is duplicative of the Systemic Errors issue that has been transferred into a group appeal.

CMS regulation interpretation is clearly not specific to only this provider, it applies to ALL SSI calculations, and as this provider is part of a chain, the Provider would be required by the CIRP regulations to pursue that challenge with related providers in a CIRP group appeal. The Provider is misplaced in trying to state that the regulatory challenge is related to any “provider specific” SSI issue that could possibly remain in an individual appeal.

Because the Systemic Errors issue was transferred to a group, the Board dismisses this aspect of the SSI Provider Specific issue.

The second aspect of the SSI Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider’s DSH percentage, “[i]f a hospital prefers that CMS use its cost reporting

¹² See Provider’s Individual Appeal Request at Tab 3.

¹³ *Id.* at Tab 3, Issue 1.

¹⁴ *Id.*

¹⁵ *Id.*

data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request” Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes.

Issue 2 – Medicaid Eligible Days

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. Regulation dictates that a provider must preserved its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

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

However, *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) (“*Banner*”) holds that a provider cannot be held to the claim preservation/presentation requirement of 42 C.F.R. § 405.1835(a)(1) when the provider is challenging a Medicare regulation or policy which the Medicare contractor has no authority to entertain or decide (such as a challenge to a Medicare regulation or policy).¹⁶ The *Banner* court explained its decision as:

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

The *Banner* court looked to *Bethesda Hosp. Ass’n v. Bowen*, 485 U.S. 399 (1988) (“*Bethesda*”) which also addressed a challenge to a regulation which was not first presented to the Medicare contractor.¹⁷ *Bethesda* holds that a provider need not protest self-disallowed costs that are barred

¹⁶ 42 C.F.R. 405.1835(a)(1)(2013).

¹⁷ *Banner* at 141.

from being claimed because of a specific statute, regulation, or ruling.¹⁸The Supreme Court in *Bethesda* stated:

[T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.

CMS recently issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to follow the holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a PRRB hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a PRRB hearing for such an item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."¹⁹

Analysis of the DSH Medicaid Eligible Days Under Ruling 1727

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on May 26, 2017 and the appeal was open on April 23, 2018, thus it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end December 31, 2014 cost report, thus the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."²⁰

Under Sections 1815(a) and 1833(e) of the Social Security Act, no Medicare payments are made to a provider unless the provider has furnished information requested by the Secretary so that the Secretary may determine the amount of payment due. With respect to a hospital's Medicare DSH payment—comprised of the Medicare and Medicaid DSH fractions—part of the Secretary's regulations mandate that a DSH-eligible hospital "has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed...and of verifying with the

¹⁸ *Bethesda Hosp. Ass'n v. Bowen*, 485 U.S. 399 (1988) at 404.

¹⁹ Ruling 1727 at unnumbered page 2.

²⁰ Ruling 1727 at 6.

State that a patient was eligible for Medicaid during each claimed patient hospital day.” 42 C.F.R. § 412.106(b)(4)(iii) (2010).

As the pertinent DSH regulations instruct that a provider is required to furnish Medicaid patient verification information to the Medicare contractor, and because the time frame within which a hospital must file its cost report is also set by regulation, the Board could find that the Provider’s DSH Medicaid Eligible Days issue “was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider.”

However, it should be noted that the Provider has not argued in its appeal thus far (final position papers have not been submitted) that there were any delays in receiving the necessary information from the State. In its appeal request, the Provider argues that the Medicare Contractor, contrary to regulation, failed to include all Medicaid eligible days in its DSH calculation.²¹ In its response to the jurisdictional challenge, the Provider focuses on arguing that the presentment requirement is not valid and that DSH does not have to be claimed or audited to give rise to jurisdiction. The Provider does not outline the difficulties it had in timely claiming all of its Medicaid eligible days, as the Board might have required under the *Banner* analysis.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board’s assessment of whether a provider’s appeal has met the jurisdictional requirements set out in the applicable regulation.²² As the Provider’s appeal was timely filed and the estimated amount in controversy is over \$10,000, the first two Board jurisdictional requirements have been met. With respect to the “dissatisfaction” requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an “allowable” item. In the instant appeal, the DSH Medicaid Eligible Days sought are not within the payment authority or discretion of the Medicare Contractor because Provider could not prove or verify eligibility with the State in time to include the Days on the Provider’s cost report, as required by regulation.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, these DSH Medicaid Eligible Days are “non-allowable” costs because the Medicare Contractor was bound by the proof of eligibility regulation at 42 C.F.R. § 412.106(b)(4)(iii), and it is recommended that the Board “not apply the self-disallowance jurisdiction regulation” in its jurisdictional decision.

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

²¹ Provider’s Appeal Request at Issue 7.

²² 42 C.F.R. § 405.1835(a) (2010).

Notwithstanding the lack of evidence and argument put forth by the Provider, the Board finds that the DSH Medicaid Eligible Days issue is within the Board's jurisdiction, based upon the *Banner* rationale and Ruling 1727-R, as it would have been futile to present DSH Medicaid Eligible Days to the Medicare Contractor without proof of eligibility and State verification. However, Board make it clear that only those DSH Medicaid Eligible Days which were not able to be verified prior to the cost report filing date are subject to the Board's jurisdiction under *Banner* and Ruling 1727-R, and that the Provider and the Medicare Contractor shall, based on information privy to these two parties, ascertain the DSH Medicaid Eligible Days that are subject to the Board's jurisdiction.

Medicare Part C and Dual Eligible Days Duplicate Issues

The Board finds that Issue 5, Medicaid Fraction/Medicare Managed Care Days and issue 8, Medicare Managed Care Days, are duplicative. The Board agrees to consolidate Issue 5 into Issue 8, which has been transferred to a group appeal, case no. 17-0574GC (QRS HMA 2014 DSH Medicaid Fraction Managed Care Part C Days Group). Similarly, the Board finds that Issue 6, Medicaid Fraction/Dual Eligible Days and Issue 9, Dual Eligible Days, are duplicative. The Board grants consolidation of Issue 6 into Issue 9, which has been transferred to a group appeal, case no. 17-0577GC (QRS HMA 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group).

Conclusion

The Board finds that it does not have jurisdiction over the SSI Provider Specific issue because it is duplicative of the SSI Systemic errors issue transferred to a group and there is no final determination with respect to the realignment portion of the issue. The Board finds that it has jurisdiction over the Medicaid eligible days that could not be verified prior to the cost report filing based on the rationale in *Banner*.

The Board grants consolidation over Issues 5 and 8 (Medicare Managed Care) and Issues 6 and 9 (Dual eligible days) as they are duplicative issues. These issues were transferred to case numbers 17-0574GC and 17-0577GC. The UCC Distribution Pool issue was transferred to a group appeal, so that challenge will not be addressed at this time.

Case no. 17-1589 will remain open and the Medicaid Eligible Days issue will be scheduled for hearing.

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:

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

FOR THE BOARD

3/7/2019

X Gregroy H. Ziegler

Gregroy H. Ziegler, CPA, CPC-A

Board Member

Signed by: Gregory H. Ziegler -A

cc: Wilson Leong, FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Michael G. Newell
Southwest Consulting Associates
2805 Dallas Parkway
Suite 620
Plano, TX 75093-8724

RE: *Expedited Judicial Review Determination*

15-2672GC SWC Crozer Keystone 2012 DSH SSI Fraction Part C Days Group
15-2673GC SWC Crozer Keystone 2012 DSH Medicaid Fraction Part C Days Group
16-0427GC SWC Partners 2013 DSH Medicaid Fraction Part C Days Group
16-0428GC SWC Partners 2013 DSH SSI Fraction Part C Days Group

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 12, 2019 request for expedited judicial review (EJR) (received February 14, 2019) for the above-referenced appeals. The Board's determination is set forth below.

The issue in these appeals is:

[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.¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR Request at 4.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

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

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.⁹

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ 42 C.F.R. § 412.106(b)(2)-(3).

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.¹⁰

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹¹ stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹²

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.¹³

¹⁰ 42 C.F.R. § 412.106(b)(4).

¹¹ of Health and Human Services

¹² 55 Fed. Reg. 35,990, 39,994 (Sept. 4, 1990).

¹³ *Id.*

With the creation of Medicare Part C in 1997,¹⁴ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁵

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

*. . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction (Emphasis added.)*¹⁶

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."¹⁷ In response to a comment regarding this change, the Secretary explained that:

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

¹⁴ The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999" This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

¹⁵ 69 Fed. Reg. 48,918, 49,099 (Aug. 11, 2004).

¹⁶ 68 Fed. Reg. 27,154, 27,208 (May 19, 2003).

¹⁷ 69 Fed. Reg. at 49,099.

*beneficiaries in the Medicare fraction if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*¹⁸ (Emphasis added)

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.¹⁹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²⁰ As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (“*Allina I*”),²¹ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH Policy adopted in the FFY 2005 final rule.²² However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²³ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁴ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁵ Once again, the Secretary has not acquiesced to this decision.

¹⁸ *Id.*

¹⁹ 72 Fed. Reg. 47,130, 47,384 (Aug. 22, 2007).

²⁰ 72 Fed. Reg. at 47,411.

²¹ 746 F. 3d 1102 (D.C. Cir. 2014).

²² 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²³ 863 F.3d 937 (D.C. Cir. 2017).

²⁴ *Id.* at 943.

²⁵ *Id.* at 943-945.

Providers' Request for EJR

The issue under appeal in this case involves the question of whether Medicare Part C patients are "entitled to benefits" under Part A, thereby requiring them to be counted in the Medicare Part A/SSI fraction and excluded from the Medicaid fraction numerator or vice versa.

Prior to 2004, the Secretary treated Part C patients as not entitled to benefits under Part A. From 1986-2004, the Secretary interpreted the term "entitled to benefits under Part A" to mean covered or paid by Medicare Part A. In the final rule for the FFY 2005, the Secretary reversed course and announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective October 1, 2004.²⁶

In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule was not a logical outgrowth of the proposed rule."²⁷ The Providers point out that because the Secretary has not acquiesced to the decision, 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).

In these cases, the Providers contend that all Part C days should be excluded from the Part A/SSI fraction and the Medicaid-eligible Part C days should be included in the numerator of the Medicaid fraction. To obtain relief, the Providers seek a ruling on the procedural and substantive validity of the 2004 rule that the Board lacks the authority to grant. The Providers maintain that since the Secretary has not acquiesced to the decision in *Allina*, the Board remains bound by the regulation. Hence, EJR is appropriate.

Decision of the Board

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

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2012-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-

²⁶ 69 Fed. Reg. at 49,099.

²⁷ *Allina I*, 746 F.3d at 1109.

disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").²⁸ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.²⁹

On August 21, 2008, new regulations governing the Board were effective.³⁰ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³¹ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³²

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

The Board has determined that the participants appeal of the Part C days are self-disallowed costs which are governed by CMS Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal and the participants' appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Based on

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

²⁹ *Bethesda* at 1258-59.

³⁰ 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

³¹ 201 F. Supp. 3d 131 (D.D.C. 2016).

³² *Banner* at 142.

the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers.

Board's Analysis Regarding the Appealed Issue

The group appeals in this EJR request involve the fiscal years 2012-2013. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).³³ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁴ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in the group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are not finding of fact for resolution by the Board.
- 3) It is bound by (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers

³³ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁴ See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating

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

For the Board:

3/12/2019

 Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions (Electronic delivery w/Schedule of Providers)
Pam VanArsdale, NGS (Electronic delivery w/Schedule of Providers)
Wilson Leong, FSS (Electronic delivery w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Stephanie A. Webster, Esq.
Akin Gump Straus Hauer & Feld LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1564

RE: *Expedited Judicial Review Determination*
16-1065GC Infirmery HS 2007 Part C Days Group
13-1039GC McKay 2008 DSH Part C Days Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 8, 2019 request for expedited judicial review (EJR) (received February 11, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

Whether "enrollees in [Medicare] Part C are 'entitled to benefits' under Part A, such that they should be counted in the Medicare [Part A/SSI¹] fraction, or whether, if not regarded as 'entitled to benefits under Part A,' they should instead be included in the Medicaid fraction" of the DSH² adjustment.³

Statutory and Regulatory Background: Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the prospective payment system ("PPS").⁴ Under PPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.⁵

¹ "SSI" is the acronym for "Supplemental Security Income."

² "DSH" is the acronym for "disproportionate share hospital."

³ Providers' EJR Request at 4.

⁴ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁵ *Id.*

The PPS statute contains a number of provisions that adjust reimbursement based on hospital-specific factors.⁶ These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased PPS payments to hospitals that serve a significantly disproportionate number of low-income patients.⁷

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").⁸ As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.⁹ The DPP is defined as the sum of two fractions expressed as percentages.¹⁰ Those two fractions are referred to as the "Medicare/SSI" fraction and the "Medicaid" fraction. Both of these fractions consider whether a patient was "entitled to benefits under part A."

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter¹¹

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.¹²

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

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were *not entitled to benefits under part A of this subchapter*, and the denominator of which is the total number of the hospital's patient days for such period.¹³

⁶ See 42 U.S.C. § 1395ww(d)(5).

⁷ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁹ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

¹⁰ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹¹ (Emphasis added.)

¹² 42 C.F.R. § 412.106(b)(2)-(3).

¹³ (Emphasis added.)

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A, and divides that number by the total number of patient days in the same period.¹⁴

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹⁵ stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹⁶

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.¹⁷

With the creation of Medicare Part C in 1997,¹⁸ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their

¹⁴ 42 C.F.R. § 412.106(b)(4).

¹⁵ of Health and Human Services.

¹⁶ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁷ *Id.*

¹⁸ The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in

care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁹

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction*²⁰

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."²¹ In response to a comment regarding this change, the Secretary explained that:

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

Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999" This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

¹⁹ 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

²⁰ 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

²¹ 69 Fed. Reg. at 49099.

associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.²²

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPSS final rule was issued.²³ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPSS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²⁴ As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* (*Allina I*),²⁵ vacated both the FFY 2005 IPSS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPSS final rule codifying the Part C DSH policy adopted in FFY 2005 IPSS rule.²⁶ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price* (*Allina II*),²⁷ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁸ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁹ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJR

The Providers point out that, prior to the 2004 rulemaking, in which the Secretary attempted to adopt a new policy to begin counting Part C days in the Medicare Part A/SSI fraction, the Secretary treated Part C patients as not entitled to benefits under Part A, rather they should be included in the Medicaid fraction of the DSH adjustment.³⁰ In the May 2003 proposed rule for Federal fiscal year 2004, the Secretary proposed “to clarify” her long held position that “once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not

²² *Id.* (emphasis added).

²³ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²⁴ 72 Fed. Reg. at 47411.

²⁵ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁶ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPSS rule). See also *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁷ 863 F.3d 937 (D.C. Cir. 2017).

²⁸ *Id.* at 943.

²⁹ *Id.* at 943-945.

³⁰ Providers’ EJR Request at 4 (citing to *Allina I*, 746 F.3d at 1105).

be included in the Medicare fraction of the DSH patient percentage.”³¹ Further, the Secretary went on, “[t]hese days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patients’ days for a [Part C] beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction.”³² The Secretary explained that, “once a beneficiary has elected to join a Medicare Advantage plan, that beneficiary’s benefits are no longer administered under Part A.”³³

However, in the final rule for the Federal fiscal year 2005, the Secretary reversed course and announced a policy to include Part C days in the Medicare Part A/SSI fraction and exclude the Part C days from the Medicaid fraction effective October 1, 2004.³⁴ The Secretary’s actions were litigated in *Allina I* in which the Court concluded that the Secretary’s final rule was not a logical outgrowth of the proposed rule and a *vacatur* was warranted.³⁵

The Providers are seeking EJR over the appeal because the Board does not have the authority to adjudicate the continued application of the 2004 rule and its policy change to the applicable portion of the cost years at issue.³⁶ The Providers point out that the Board continues to be bound by the regulation on Part C days unless the Secretary acquiesces in the *Allina* court rulings, which he has not done.³⁷

Decision of the Board

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

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2007-2008.

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

³¹ 68 Fed Reg. at 27208.

³² *Id.*

³³ *Id.*

³⁴ 69 Fed Reg. 49099 (Aug. 11, 2004).

³⁵ Providers’ EJR Request at 5-6.

³⁶ *Id.* at 10 (citing 42 C.F.R. § 405.1867) (stating “in exercising its authority to conduct proceedings under this subpart, the Board must comply with all the provisions of Title XVIII of the Act and the regulations thereunder.”).

³⁷ *Id.*

Association v. Bowen (Bethesda).³⁸ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³⁹

On August 21, 2008, new regulations governing the Board were effective.⁴⁰ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").⁴¹ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.⁴²

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

The Board notes that Case No. 16-1065GC contains a single provider, as a result, the Board is electing to treat this case an individual appeal for purposes of jurisdiction. The Board has determined that the remaining participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for

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

³⁹ *Bethesda*, 108 S. Ct. at 1258-59.

⁴⁰ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

⁴¹ 201 F. Supp. 3d 131 (D.D.C. 2016)

⁴² *Id.* at 142.

a group appeal⁴³ and \$10,000 for the individual appeals.⁴⁴ The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJRs involve the 2007 and 2008 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).⁴⁵ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJRs, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.⁴⁶ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

⁴³ See 42 C.F.R. § 405.1837.

⁴⁴ See 42 C.F.R. § 405.1835.

⁴⁵ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

⁴⁶ See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

FOR THE BOARD:

3/12/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (Electronic Mail w/Schedules of Providers)
Cecile Huggins, Palmetto GBA (Electronic Mail w/Schedules of Providers)
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Dylan Chinaea
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108

RE: *Jurisdictional Determination*
Dignity Health IRF-LIP Group Appeals
Provider Nos.: Various
FYE: 2007-2015
PRRB Case Nos.: *See Appendix A*

Dear Mr. Chinaea and Ms. Frewert:

This case involves the Providers' appeals of its Medicare reimbursement for the fiscal years ending ("FYE") in 2007 through 2015. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' documentation on its own motion in response to the decision of U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* on June 8, 2018 ("*Mercy*").¹ 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") reimbursement issue and dismisses the instant appeals.

Pertinent Facts

On the dates seen in Appendix A, the Board received the group representative's requests for a hearing ("RFH") regarding Notices of Program Reimbursement ("NPR"), corresponding to FYEs ending in 2007 through 2015. In its RFH, the Providers' list a single issue for appeal — the calculation of the Low-Income Patient ("LIP") fraction of the Medicare DSH payment for inpatient rehabilitation distinct-part units ("IRFs").

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

¹ *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).

\$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.²

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.”³ 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 U.S. District Court, wherein the U.S. 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.⁴ 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.⁵

In the instant appeals, the Providers seek Board review of one of the components utilized by the Medicare Contractor to determine the Provider’s LIP adjustment, namely its SSI or Medicare—Ratio. As 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 appeal of the LIP adjustment and dismisses the issue in the instant appeals that challenge this adjustment. In making this finding, the Board notes that

² *Id.*

³ *Id.* at 1064.

⁴ *Mercy Hosp., Inc. v. Burwell*, 206 F. Supp. 3d 93, 102 (D.D.C. 2016).

⁵ *Mercy*, 891 F.3d at 1068.

the D.C. Circuit's decision in *Mercy* is controlling precedent for interpreting the statutory provisions at issue because the Providers could bring suit in the D.C. Circuit.⁶

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

Board Members Participating:

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

For the Board:

3/13/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

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

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 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).

APPENDIX A

Case No. 17-0146GC – Dignity Health 2007 LIP Accuracy of CMS Developed SSI Ratio Issued 3/16/2016 CIRP Group	RFH Letter: 10/17/2016
Case No. 16-2509GC – Dignity Health 2008 LIP Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 9/19/2016
Case No. 17-0142GC – Dignity Health 2009 LIP Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-0139GC – Dignity Health 2010 LIP Accuracy of CMS Developed SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-1933GC – Dignity Health 2011 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	RFH Letter: 7/13/2017
Case No. 17-1853GC – Dignity Health 2012 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 17-1857GC – Dignity Health 2013 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 18-0541GC – Dignity Health 2014 LIP Accuracy of CMS Developed SSI Ratio CIRP Group	RFH Letter: 1/22/2018
Case No. 17-0147GC – Dignity Health 2007 LIP Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 16-2510GC – Dignity Health 2008 LIP Inclusion of Medicare Part A Unpaid Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 9/19/2016
Case No. 17-0143GC – Dignity Health 2009 LIP Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-0140GC – Dignity Health 2010 LIP Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-1934GC – Dignity Health 2011 LIP Dual Eligible Part A Days in the SSI Ratio CIRP Group	RFH Letter: 7/13/2017
Case No. 17-1854GC – Dignity Health 2012 LIP Dual Eligible Part A Days in the SSI Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 17-1860GC – Dignity Health 2013 LIP Dual Eligible Part A Days in the SSI Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 17-0148GC – Dignity Health 2007 LIP Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 16-2511GC – Dignity Health 2008 LIP Inclusion of Medicare Part C Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 9/19/2016
Case No. 17-0144GC – Dignity Health 2009 LIP Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-0141GC – Dignity Health 2010 LIP Inclusion of Dual Eligible Part C Days in SSI Ratio Issued 3/16/2012 CIRP Group	RFH Letter: 10/17/2016
Case No. 17-1938GC – Dignity Health 2011 LIP Dual Eligible Part C Days in the SSI Ratio CIRP Group	RFH Letter: 7/13/2017
Case No. 17-1855GC – Dignity Health 2012 LIP Dual Eligible Part C Days in the SSI Ratio CIRP Group	RFH Letter: 7/14/2017

Case No. 17-1861GC – Dignity Health 2013 LIP Dual Eligible Part C Days in the SSI Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 18-0542GC – Dignity Health 2014 LIP Medicare Part C Days in the SSI Ratio CIRP Group	RFH Letter: 1/22/2018
Case No. 18-1418GC – Dignity Health 2015 LIP Medicare Part C Days in the SSI Ratio CIRP Group	RFH Letter: 6/29/2018
Case No. 19-0343GC – Dignity Health CY 2012 LIP Exclusion of Dual Eligible Part C Days - Medicaid Ratio CIRP Group	RFH Letter: 11/19/2018
Case No. 17-1858GC – Dignity Health 2013 LIP Exclusion of Dual Eligible Part A Unpaid Days - Medicaid Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 17-1859GC – Dignity Health 2013 LIP Exclusion of Dual Eligible Part C Unpaid Days - Medicaid Ratio CIRP Group	RFH Letter: 7/14/2017
Case No. 18-1417GC – Dignity Health 2015 LIP Exclusion of Dual Eligible Part C Days - Medicaid Ratio CIRP Group	RFH Letter: 6/29/2018



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Mail

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

RE: *Expedited Judicial Review Determination*

14-1026G Hall Render 2011 DSH Medicare/Medicaid Part C Days Group
15-1674G Hall Render 2011 DSH Medicare/Medicaid Part C Days Group II
15-3009GC Thomas Health System 2010 DSH Medicare/Medicaid Part C Days Group
18-0131G Hall Render 2014 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 21, 2019 request for expedited judicial review (EJR) (received February 22, 2019). The Board's determination is set forth below.

Issue

The issue for which EJR has been requested is:

The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR Request at 2.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter⁹

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

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ (Emphasis added.)

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

¹¹ (Emphasis added.)

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹³ stated that:

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

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

¹² 42 C.F.R. § 412.106(b)(4).

¹³ of Health and Human Services.

¹⁴ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁵ *Id.*

With the creation of Medicare Part C in 1997,¹⁶ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁷

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction¹⁸

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

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

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

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

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

¹⁹ 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.²¹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²² As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²³ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.²⁴ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁵ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁶ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁷ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJRs

The Providers assert that that the Medicare fraction of the DSH calculation is improperly understated due to the Secretary’s erroneous inclusion of inpatient days attributable to Medicare

²⁰ *Id.* (emphasis added).

²¹ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²² 72 Fed. Reg. at 47411.

²³ 746 F.3d 1102 (D.C. Cir. 2014).

²⁴ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁵ 863 F.3d 937 (D.C. Cir. 2017).

²⁶ *Id.* at 943.

²⁷ *Id.* at 943-945.

Advantage patients in both the numerator and the denominator of the of the Medicare fraction. The failure to include such days in the Medicaid fraction also understated that fraction. The Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f).²⁸

In challenging the validity of the regulation, the Providers assert that the regulation was adopted in violation of the Administrative Procedures Act (APA). They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on the regulation. This position was upheld in the decisions in both *Allina I* and *Allina II*.²⁹

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare ratio for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare ratio is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.³⁰

With respect to EJRs, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I* and *Allina II* decisions until the Secretary instructs it to do so.³¹

Decision of the Board

Board's Authority

Under the Medicare statute codified at 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2016), the Board is required to grant a provider's EJR request if it determines that (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue

²⁸ *Id.* at 2.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.* at 7

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.

Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving cost reporting periods ending in 2010-2014 (FY 2013 and prior).

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen (Bethesda)*.³² In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³³

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

The Secretary did not appeal the decision in *Banner* and decided to apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008, and which began before January 1, 2016. Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left

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

³³ *Bethesda at 1258-59.*

³⁴ 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).

³⁵ 201 F. Supp. 3d 131 (D.D.C. 2016).

³⁶ *Banner at 142.*

it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that participants involved with the instant EJR request which appeal original Notices of Program Reimbursement are governed by the provisions of *Bethesda* and CMS Ruling 1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal³⁷ and the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding Its Authority to Consider the Appealed Issue

The Providers within this EJR request filed appeals covering cost reporting periods ending in 2010-2014 (FY 2013 and prior). Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).³⁸ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁹ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) it has jurisdiction over the matter for the subject years and the Providers in this appeal are entitled to a hearing before the Board;
- 2) Based upon the Providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;

³⁷ See 42 C.F.R. § 405.1837.

³⁸ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁹ See 42 U.S.C. § 1395oo(f)(1).

- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

Board Members Participating:

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

FOR THE BOARD:

3/15/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Bryon Lamprecht, WPS (Electronic Mail w/Schedules of Providers)
Laurie Polston, Palmetto GBA c/o NGS (Electronic Mail w/Schedules of Providers)
Lorraine Frewert, Noridian (Electronic Mail w/Schedules of Providers)
Wilson Leong, FSS (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Mail

Robert L. Roth, Esq.
Hooper, Lundy and Bookman, P.C.
401 9th Street, NW
Suite 550
Washington, D.C. 20004

RE: *Expedited Judicial Review Determination*

Case No. 16-1126G HLB 2008 DSH Part C Days Medicaid and Medicare/SSI Fractions Grp.

Dear Mr. Roth:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' January 25, 2019 request for expedited judicial review (EJR), for the above-referenced appeal, as well as the Providers' February 22, 2019 response to the Board's February 21, 2019 request for additional information. The Board's determination is set forth below.

Issue in Dispute

The issue in this appeal is:

Whether the Hospitals' FY 2008 Medicare DSH [*i.e.* disproportionate share hospital] payments were understated because (a) the numerator of the Medicaid fraction improperly excluded inpatient hospital days attributable to dually-eligible Medicare Part C plan enrollee patients and (b) the Medicare/SSI fraction improperly included inpatient hospital days attributable to Medicare Part C enrollee patients.¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR request at 1.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter⁹

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

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ (Emphasis added.)

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.¹¹

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹³ stated that:

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

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

¹¹ (Emphasis added.)

¹² 42 C.F.R. § 412.106(b)(4).

¹³ of Health and Human Services.

¹⁴ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁵ *Id.*

With the creation of Medicare Part C in 1997,¹⁶ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁷

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction¹⁸

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

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

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

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

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

¹⁹ 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPSS final rule was issued.²¹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPSS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²² As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²³ vacated both the FFY 2005 IPSS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPSS final rule codifying the Part C DSH policy adopted in FFY 2005 IPSS rule.²⁴ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁵ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁶ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁷ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJR

The Providers are challenging the inclusion of Part C days in the Medicare/SSI fraction and the exclusion of dually-eligible Medicare Part C days from the numerator of the Medicaid fraction,

²⁰ *Id.* (emphasis added).

²¹ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²² 72 Fed. Reg. at 47411.

²³ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁴ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPSS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁵ 863 F.3d 937 (D.C. Cir. 2017).

²⁶ *Id.* at 943.

²⁷ *Id.* at 943-945.

used to calculate their DSH payments based on the Secretary's invalid Part C DSH policy adopted in the FFY 2005 IPPS final rule (which the Secretary improperly sought to impose without notice and comments rulemaking in 2007 in the FFY 2008 IPPS final rule). The Providers note that although the Board has jurisdiction over the DSH Medicare Part C Days Medicaid and Medicare/SSI fractions issue, they believe that the Board lacks the authority to make any changes to CMS policy. They believe that EJRs are appropriate where there is a challenge over the substantive and procedural validity of the rule requiring the inclusion of Part C days in the Medicare/SSI fraction.

Decision of the Board

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

Jurisdictional Determination

The participants in this EJR request have filed appeals involving cost reporting periods ending in 2008.

The Board reviewed the updated Schedule of Providers and supporting jurisdictional documents that were submitted on February 22, 2019 in response to the Board's letter advising you that the earlier submission was not in compliance with the Board Rules. The documentation that you resubmitted complied with the Board's rules *except that* documentation for Tabs D and E (the audit adjustments and calculation of the reimbursement effect) were not submitted. Although there continued to be issues with the document submission, *as a courtesy*, the Board staff reviewed the group and individual files for these 2 providers in the case and located the missing documentation to cure the deficiencies in your submission. While the Board was able to extend this courtesy to you in this instance, the Board expects that, for future submissions, you will cure the issues noted in this letter and earlier correspondence from the Board. In particular, ***for future Board submissions of the Schedule of Providers and supporting documentation, please ensure that the jurisdictional submission for all providers in a group appeal include Tabs A, B, D, E, G and H with the required documentation placed under the correct tab in compliance with Board Rules.***

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

Association v. Bowen (Bethesda).²⁸ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.²⁹

On August 21, 2008, new regulations governing the Board were effective.³⁰ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell (Banner)*.³¹ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJRs was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³²

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

The Board has determined that participants involved with the instant EJR requests of Medicare Part C days issue are governed by the decision in *Bethesda* and CMS Ruling-1727-R, consequently, the Board has jurisdiction over the appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal³³ and the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated

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

²⁹ *Bethesda* at 1258-59.

³⁰ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³¹ 201 F. Supp. 3d 131 (D.D.C. 2016)

³² *Banner* at 142.

³³ See 42 C.F.R. § 405.1837.

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

Board's Analysis Regarding the Appealed Issue

The appeals in this EJIR request involve 2008 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).³⁴ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJIR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁵ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJIR request.

Board's Decision Regarding the EJIR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and, hereby, grants the Providers' request for EJIR for the issue and the subject year.

³⁴ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁵ See 42 U.S.C. § 1395oo(f)(1).

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

Board Members Participating:

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

FOR THE BOARD:

3/15/2019

X Clayton J. Nix.

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

Enclosures: Schedule of Providers

cc: Bruce Synder, Novitas (Electronic Mail w/ Schedule of Providers)
Wilson Leong, Esq., Federal Specialized Services (Electronic Mail w/Schedule of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Mail

Isaac Blumberg
Blumberg Ribner, Inc.
315 South Beverly Drive
Suite 505
Beverly Hills, CA 90212-1925

RE: *Expedited Judicial Review Determination*

19-1240GC Continuum Health Partners 2011 Medicare HMO Part C Days Medicare Fraction
19-1244GC Continuum Health Partners 2011 Medicaid HMO Part C Days Medicaid Fraction

Dear Mr. Blumberg:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' February 22, 2019 request for expedited judicial review (EJR) (received February 25, 2019), for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

Whether 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 consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR request at 1.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter⁹

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

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ (Emphasis added.)

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

¹¹ (Emphasis added.)

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹³ stated that:

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

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

¹² 42 C.F.R. § 412.106(b)(4).

¹³ of Health and Human Services.

¹⁴ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁵ *Id.*

With the creation of Medicare Part C in 1997,¹⁶ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁷

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A. . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction*¹⁸

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

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

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

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

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

¹⁹ 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPSS final rule was issued.²¹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPSS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²² As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²³ vacated both the FFY 2005 IPSS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPSS final rule codifying the Part C DSH policy adopted in FFY 2005 IPSS rule.²⁴ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁵ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁶ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁷ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJER

The Providers assert that EJER is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, “the 2004 regulation requiring Part C days be included in the

²⁰ *Id.* (emphasis added).

²¹ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²² 72 Fed. Reg. at 47411.

²³ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁴ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPSS rule). See also *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁵ 863 F.3d 937 (D.C. Cir. 2017).

²⁶ *Id.* at 943.

²⁷ *Id.* at 943-945.

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).²⁸ The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJR is appropriate since the Board is bound by the regulation.

Decision of the Board

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

Jurisdictional Determination

The participants in this EJR request have filed appeals involving fiscal year 2011.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").²⁹ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³⁰

On August 21, 2008, new regulations governing the Board were effective.³¹ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³² In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over

²⁸ Request for EJR at 1.

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

³⁰ *Bethesda* at 1258-59.

³¹ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³² 201 F. Supp. 3d 131 (D.D.C. 2016)

the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³³

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

The Board has determined that participants involved with the instant EJR requests are governed by CMS Ruling-1727-R, consequently, the Board has jurisdiction over the appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal³⁴ and the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve the 2011 cost reporting period. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPSS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPSS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).³⁵ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁶ Based on the above, the Board must conclude that it is otherwise bound by these regulations for purposes of this EJR request.

³³ *Banner* at 142.

³⁴ See 42 C.F.R. § 405.1837.

³⁵ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁶ See 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the EJER Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject year and that the Providers are entitled to a hearing before the Board;
- 2) Based upon the providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPSS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJER for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

3/19/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (Electronic Mail w/ Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

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

RE: *Expedited Judicial Review Determination*

15-3325GC Valley Health 2011 DSH Part C Days Group
16-0002GC Thomas Health System 2011 DSH Part C Days Group
16-0600GC Thomas Health System 2012 DSH Part C Days Group
16-1599GC Truman Medical Centers, Inc. 2013 DSH Medicare/Medicaid Part C Days Group
17-1769G Hall Render 2012 DSH Medicare/Medicaid Part C Days Group

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 27, 2019 request for expedited judicial review ("EJR") (received February 28, 2019) for the appeals referenced above. The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

The improper inclusion by the [Medicare Contractor] and the Centers for Medicare & Medicaid Services (CMS) of inpatient days attributable to Medicare Advantage patients in the numerator and [denominator] of the Medicare Proxy when calculating the disproportionate share hospital (DSH) eligibility and payments.¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR Request at 1.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter⁹

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

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ (Emphasis added.)

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.¹¹

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹³ stated that:

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

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

¹¹ (Emphasis added.)

¹² 42 C.F.R. § 412.106(b)(4).

¹³ of Health and Human Services.

¹⁴ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁵ *Id.*

With the creation of Medicare Part C in 1997,¹⁶ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁷

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction¹⁸

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

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

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

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

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

¹⁹ 69 Fed. Reg. at 49099.

is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.²⁰

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.²¹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²² As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²³ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.²⁴ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁵ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁶ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁷ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJR

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

²⁰ *Id.* (emphasis added).

²¹ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²² 72 Fed. Reg. at 47411.

²³ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁴ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSII calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁵ 863 F.3d 937 (D.C. Cir. 2017).

²⁶ *Id.* at 943.

²⁷ *Id.* at 943-945.

Providers point out that the authority upon which CMS relied to collect Medicare Advantage days information is the DSH regulation at 42 C.F.R. § 412.106, which includes Medicare Advantage days in the description of the days included in the Medicare fraction. However, the enabling statute for this regulation, 42 U.S.C. § 1395ww(d)(5)(f), makes no mention of the inclusion of Medicaid Advantage days in the Medicare fraction, only traditional Part A days. The Providers contend that Medicare Advantage beneficiaries are not entitled to benefits under Part A, but instead are entitled to benefits under Part C. As a result, the Providers are challenging the validity of the regulation to the extent that 42 C.F.R. § 412.106 contradicts the enabling statute at 42 U.S.C. § 1395ww(d)(5)(f) as it relates to including Part C days in the Medicare fraction.²⁸

In challenging the validity of the regulation at § 412.106(b) as it relates to including Part C days in the Medicare fraction, the Providers assert that this regulation was adopted in violation of the Administrative Procedures Act (APA). They recognize that this regulation was codified as part of the technical correction made in the FFY 2008 Final Rule. They contend that the Secretary violated the APA when she deprived the public the opportunity to comment on this regulation. This position was upheld in the decisions in both *Allina I* and *Allina II*.²⁹

The Providers argue that any Medicare Advantage days that are also dual eligible days cannot be counted in the Medicare fraction for the same reasons as set forth above. Primarily, they believe, the regulation requiring inclusion of dual eligible days in the Medicare fraction is invalid and the days must be counted in numerator of the Medicaid fraction. This allegedly improper treatment resulted in the under payment to Providers as DSH eligible providers of services to indigent patients, and includes any other related adverse impact to DHS payments, such as capital DSH payments.³⁰

With respect to EJRs, the Providers believe that the Board has jurisdiction over the matter at issue and lacks the legal authority to decide the legal question presented. The Providers posit that the Board is not able to address the legal question of whether CMS correctly followed the statutory mandates for rulemaking set forth in the APA and the statute and is bound by Secretary's actions. The Providers do not believe that the Board has the authority to implement the effect of *Allina I*.

Decision of the Board

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

²⁸ *Id.* at 2.

²⁹ *Id.*

³⁰ *Id.*

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2011-2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").³¹ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³²

On August 21, 2008, new regulations governing the Board were effective.³³ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³⁴ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³⁵

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

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

³² *Bethesda*, 108 S. Ct. at 1258-59.

³³ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³⁴ 201 F. Supp. 3d 131 (D.D.C. 2016)

³⁵ *Id.* at 142.

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

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal³⁶ and the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. Based on the above, the Board finds that it has jurisdiction over the above-captioned group cases and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2011-2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).³⁷ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁸ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board;
- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

³⁶ See 42 C.F.R. § 405.1837.

³⁷ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁸ See 42 U.S.C. § 1395oo(f)(1).

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

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

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Everts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

3/19/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Laurie Polson, Palmetto GBA c/o NGS (Electronic Mail w/Schedules of Providers)
Byron Lamprecht, WPS (Electronic Mail w/Schedules of Providers)
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Mail

Isaac Blumberg
Blumberg Ribner, Inc.
315 South Beverly Drive
Suite 505
Beverly Hills, CA 90212-1925

RE: *Expedited Judicial Review Determination*

18-0402G BRI Independent Hospitals 2008 Medicare HMO Part Days-Medicare Fraction Grp 3
18-0403G BRI Independent Hospitals 2008 Medicare HMO Part Days-Medicaid Fraction Grp 3

Dear Mr. Blumberg:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' February 25, 2019 request for expedited judicial review ("EJR") (received February 26, 2019), for the above-referenced appeals. The Board's determination is set forth below.

Issue in Dispute

The issue in these appeals is:

Whether 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 consistent with the decision of the United States Court of Appeals for the District of Columbia in *Allina Health Services v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014).¹

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ Providers' EJR request at 1.

² See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

³ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter⁹

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

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

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

⁴ See 42 U.S.C. § 1395ww(d)(5).

⁵ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁶ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(I).

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁸ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

⁹ (Emphasis added.)

¹⁰ 42 C.F.R. § 412.106(b)(2)-(3).

¹¹ (Emphasis added.)

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹³ stated that:

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

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

¹² 42 C.F.R. § 412.106(b)(4).

¹³ of Health and Human Services.

¹⁴ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁵ *Id.*

With the creation of Medicare Part C in 1997,¹⁶ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁷

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction ...¹⁸

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

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

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

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

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

¹⁹ 69 Fed. Reg. at 49099.

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

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.²¹ In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²² As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²³ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.²⁴ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁵ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁶ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁷ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJR

The Providers assert that EJR is appropriate because the Secretary has not acquiesced to the decision in *Allina I*. As a result, “the 2004 regulation requiring Part C days be included in the

²⁰ *Id.* (emphasis added).

²¹ 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²² 72 Fed. Reg. at 47411.

²³ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁴ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁵ 863 F.3d 937 (D.C. Cir. 2017).

²⁶ *Id.* at 943.

²⁷ *Id.* at 943-945.

Part A/SSI fraction and removed from the Medicaid fraction remains in effective as set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²⁸ The Providers point out that they have met the timely filing requirements and the amount in controversy and believe that EJRs are appropriate since the Board is bound by the regulation.

Decision of the Board

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

Jurisdictional Determination

The participants in this EJR request have filed appeals involving cost reporting periods ending in 2008.

For purposes of Board jurisdiction over a participant's appeal for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").²⁹ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³⁰

On August 21, 2008, new regulations governing the Board were effective.³¹ Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³² In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The

²⁸ Providers' Request for EJR at 1.

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

³⁰ *Bethesda* at 1258-59.

³¹ 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³² 201 F. Supp. 3d 131 (D.D.C. 2016)

provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³³

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

The Board has determined that participants involved with the instant EJR requests either fall under Bethesda or are governed by CMS Ruling-1727-R, consequently, the Board has jurisdiction over the appeals. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal³⁴ and the appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Analysis Regarding the Appealed Issue

The appeals in this EJR request involve a 2008 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (e.g., only circuit-wide versus nationwide).³⁵ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit or the circuit within which they are located.³⁶ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

³³ *Banner* at 142.

³⁴ See 42 C.F.R. § 405.1837.

³⁵ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁶ See 42 U.S.C. § 1395oo(f)(1).

Board's Decision Regarding the EJER Request

The Board finds that:

- 1) It has jurisdiction over the matter for the subject year and that the Providers are entitled to a hearing before the Board;
- 2) Based upon the providers' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJER for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since there are no other issues under dispute in these cases, the cases are hereby closed.

Board Members Participating:

Clayton J. Nix, Esq.
Charlotte F. Benson, CPA
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

FOR THE BOARD:

3/19/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Pam VanArsdale, NGS (Electronic Mail w/ Schedules of Providers)
Wilson Leong, Esq., Federal Specialized Services (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Bricker & Eckler, LLP
Mr. James Flynn
100 South Third Street
Columbus, OH 43215-4291

CGS Administrators
Ms. Judith Cummings
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Grant Medical Center
Provider No.: 36-0017
FYE: 6/30/09
PRRB Case No.:14-0045

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in case number 14-0045. The decision of the Board is set forth below.

Background:

The Provider appealed a Notice of Program Reimbursement (“NPR”) dated April 30, 2013 for the June 30, 2009 cost reporting period.¹ The Model Form A – Individual Appeal Request, received on October 17, 2013 presented one issue: The Provider filed the appeal to “preserve its rights to obtain a shift of the calculation period of the DSH percentage from the federal fiscal year to the Provider’s cost report year, should such a shift be found desirable for the Provider.”² The Provider has requested the data from CMS to evaluate a “potential request for reopening and cost-year shift from CMS, it has not, as of the date of this appeal request, been provided with the requested information.”³

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board dismisses the Provider’s request to preserve its right to request realignment of the Supplemental Security Income (“SSI”) percentage from the federal fiscal year to its cost reporting period for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), to determine a Provider’s DSH percentage, “if a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request” Without this written request, the Medicare

¹ See Provider’s Individual Appeal Request at Tab 1.

² See Provider’s Individual Appeal Request at Tab 3, SSI Realignment.

³ *Id.*

Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. At this time, there is nothing in the record to indicate that the Provider has elected a revision to the SSI ratio based on a different fiscal period.

Conclusion:

The Board finds that it does not have jurisdiction over the SSI realignment issue and dismisses the issue from the appeal.

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

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

3/25/2019

X Gregory H. Ziegler

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

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Bricker & Eckler, LLP
Mr. James Flynn
100 South Third Street
Columbus, OH 43215-4291

CGS Administrators
Ms. Judith Cummings
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: Riverside Methodist Hospital
Provider No.: 36-0006
FYE: 6/30/09
PRRB Case No.:14-0047

Dear Mr. Flynn and Ms. Cummings,

The Provider Reimbursement Review Board (“Board”) has reviewed the jurisdictional documents in case number 14-0047. The decision of the Board is set forth below.

Background:

The Provider has appealed a Notice of Program Reimbursement (“NPR”) dated April 10, 2013 for the June 30, 2009 cost reporting period.¹ The Model Form A – Individual Appeal Request, received on October 17, 2013 presented one issue: The Provider filed the appeal to “preserve its rights to obtain a shift of the calculation period of the DSH percentage from the federal fiscal year to the Provider’s cost report year, should such a shift be found desirable for the Provider.”² The Provider has requested the data from CMS to evaluate a “potential request for reopening and cost-year shift from CMS, it has not, as of the date of this appeal request, been provided with the requested information.”³

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is \$10,000 or more (or \$50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board dismisses the Provider’s request to preserve its right to request realignment of the Supplemental Security Income (“SSI”) percentage from the federal fiscal year to its cost reporting period

¹ See Provider’s Individual Appeal Request at Tab 1.

² See Provider’s Individual Appeal Request at Tab 3, SSI Realignment.

³ *Id.*

for lack of jurisdiction. Under 42 C.F.R. § 412.106(b)(3), to determine a Provider's DSH percentage, "if a hospital prefers that CMS use its cost reporting data instead of the federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. At this time, there is nothing in the record to indicate that the Provider has elected a revision to the SSI ratio based on a different fiscal period.

Conclusion:

The Board finds that it does not have jurisdiction over the SSI realignment issue and dismisses the issue from the appeal.

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

BOARD MEMBERS PARTICIPATING:

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

FOR THE BOARD:

3/25/2019

X Gregory H. Ziegler

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

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



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Stephanie Webster
Akin Gump Strauss Hauer & Feld, LLP
1333 New Hampshire Avenue, NW
Washington, DC 20036-1594

Danene Hartley
National Government Services, Inc. (J-6)
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

Re: *Jurisdictional Decision*

Allina Health System 2008 SSI Realignment Group
Group Case No. 11-0137GC

Dear Ms. Webster and Ms. Hartley,

The Provider Reimbursement Review Board ("Board") has reviewed the record in the above-captioned appeal and determined that it does not have jurisdiction over the issue under appeal. The Board's decision is set forth below.

Medicare Contractor's Jurisdictional Challenge

This group appeal was filed on December 3, 2010. The Medicare Contractor has challenged the Board's jurisdiction over the Disproportionate Share Hospital ("DSH") Social Security Income ("SSI") percentage realignment issue arguing it is premature as none of the Providers in the group have requested their SSI percentages be recalculated from the federal fiscal year end to their own cost reporting period/fiscal year ends. The Medicare Contractor's position is that it made no adjustment to the cost report related to SSI percentage realignment and, therefore, it has not made a final determination with respect to the providers for the issue appealed as required under 42 C.F.R. § 405.1835.

Providers' Response to Jurisdictional Challenge

The Providers filed a Response to the Jurisdictional Challenge arguing they are legally dissatisfied with the determination of their SSI fractions until they can review the "routine use" data utilized, and afforded an opportunity to request recalculation of the SSI fractions. The Providers assert they have a statutory right to DSH SSI percentages which reflect the patient days associated with discharges in each hospital's own "cost reporting period" as required under 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Providers also request postponement of the hearing date in the appeal, explaining they would like 18 months to resolve other pending appeals which may affect their DSH SSI percentages.

Board Decision:

Matter at Issue in Group Appeal

Group appeals may only contain one issue as required by Board Rule 13 (2009) which states:

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...

The Providers in this appeal have stated the common issue in this group appeal is CMS' withholding of "routine use" data in violation of MMA § 951 and that they "are not requesting recalculations of their SSI fractions."¹ However, this allegation is part and parcel an SSI realignment issue² and the providers have focused on realignment rather than the MMA § 951 claim. First, the title of the group appeal as proposed by the Providers, as well as the title of the issue statement involves DSH SSI Realignment.³ To this end, the original group appeal request states that the "routine use data" is needed in order "to assess whether a recalculation of the SSI fraction [based upon the hospital's cost reporting period] is advisable."⁴

The Providers' description of their issue in the final position papers has evolved away from MMA § 951 violations to simply preserving realignment rights. In the regard, the regulations and Board rules governing position papers is relevant. 42 C.F.R. § 405.1849(b) specifies that the purpose of position papers is to "narrow issues" and that "each position paper must set forth . . . the merits of the provider's Medicare payment claims for each remaining issue." Similarly, Board Rule 27 (2015) addresses final position papers and states the following, in pertinent part:

27.1 – General

The final position paper should reflect the refinement of the issues from the preliminary position paper or proposed JSO. . . .

¹ *Model Form B – Group Appeal Request* (Dec. 3, 2010), Tab 2 at 1.

² Review of the initial provider used to form the group and the jurisdiction documents filed for that provider supports this conclusion. The Board's jurisdiction over this provider exists because the provider protested the "DSH Payments: SSI Realignment" on its cost report. The description for this protested issue states: "Whether the provider is entitled to realign their SSI percentage for the purpose of calculating their DSH payments? This cannot be determined until CMS publishes the applicable Medpar files." *See also id.* at Tab 1.

³ *Id.*

⁴ *Model Form B – Group Appeal Request* (Dec. 3, 2010), Tab 2 at 1.

27.2 – Content

The final position paper should address each remaining issue including, at a minimum:

- a. Identification of each issue and its reimbursement impact. . . .
- d. Argument and Authorities – A thorough explanation of the party’s position of how the authorities apply to the facts.

Further, Board Rule 41.2 (2015) states that the Board may dismiss an issue on its own motion “if it has a reasonable basis to believe that the issue[has] been fully settled or abandoned.”

The Providers state, in the introduction to their final position paper (“FPP”), that the appeal was filed “to *preserve* their right to have their Medicare part A/SSI fractions recalculated based on the hospitals’ cost reporting period instead of the Federal fiscal year.”⁵ As later explained in the FPP, the Providers appear to abandon the MMA § 951 issue because “CMS produced the [MMA § 951] data that purports to show the patient days included in the part A/SSI fractions that it calculated for federal fiscal years 2008 and 2009.”⁶ In the FPP, the Providers confirm that their decision on whether to pursue realignment *now* hinges on the outcome of appeals pending on other DSH day challenges such as “CMS’s inclusion of part C days as par A days in the DHS calculation” and “CMS’s inclusion of non-covered part A days in the part A/SSI fractions.”⁷ The Providers conclude in their final position paper that “[f]or the foregoing reasons, the Providers contend that they have an unqualified right to have their part A/SSI fractions recalculated upon the final resolution of their other appeals challenging CMS’ calculation of the part A/SSI fractions, without regard to the three-year reopening window.”⁸

Accordingly, the Board must conclude that the MMA § 951 issue has been abandoned because it is now moot (*i.e.*, CMS produced the requisite data) and that the sole remaining issue in this case is the DSH SSI realignment issue.

Board Jurisdiction Over the DSH SSI Realignment Issue

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

⁵ *Providers’ Final Position Paper* (Aug. 30, 2018) at 1 (emphasis added).

⁶ *Id.* at 5.

⁷ *Id.*

⁸ *Id.* at 12.

The Board finds that it does not have jurisdiction over the SSI Realignment issue in Case No. 11-0137GC because there is no final determination from which the Providers are appealing. Under 42 C.F.R. § 412.106(b)(3), a hospital can, if it prefers, use its cost reporting period (fiscal year end) data instead of the federal fiscal year end data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospital's decision alone, which then must submit a written request to the Medicare Contractor. The Providers appealed to preserve their right to request realignment; however, without these requests (and there is no evidence such requests have been made), it is not possible for the Medicare Contractor to have issued a final determination from which any of the Providers could appeal.

In conclusion, the Board does not have jurisdiction over the SSI Realignment issue in the appeal as no final determination has been made regarding this issue. Case No. 11-0137GC is hereby dismissed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. §1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

FOR THE BOARD:

3/27/2019

 Clayton J. Nix

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

cc: Wilson Leong, Esq., FSS



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: *EJR Determination*

14-0369G HRS 2007 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
14-3521G HRS 2006 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-2404GC QRS DCH 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-2405GC QRS DCH 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
17-0224G HRS 2013 DSH SSI Fraction Medicare Managed Care Part C Days Group II
17-0223G HRS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group II

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 1, 2019 request for expedited judicial review (EJR), received March 5, 2019 for the appeals referenced above.¹ The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

[W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.²

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ The Board will be issuing EJR determinations in case numbers 15-0549G and 15-0554G which were included in the March 5, 2019 EJR request in separate correspondence.

² Providers' EJR request at 1.

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

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter¹⁰

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

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

the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical

³ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁴ *Id.*

⁵ See 42 U.S.C. § 1395ww(d)(5).

⁶ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁹ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹⁰ (Emphasis added.)

¹¹ 42 C.F.R. § 412.106(b)(2)-(3).

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

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹⁴ stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹⁵

¹² (Emphasis added.)

¹³ 42 C.F.R. § 412.106(b)(4).

¹⁴ of Health and Human Services.

¹⁵ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

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

With the creation of Medicare Part C in 1997,¹⁷ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁸

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction ...¹⁹

The Secretary purportedly changed her position in the Federal fiscal year (“FFY”) 2005 IPPS final rule, by noting she was “revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation.”²⁰ In response to a comment regarding this change, the Secretary explained that:

... We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are

¹⁶ *Id.*

¹⁷ The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) “Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999” This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

¹⁸ 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

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

²⁰ 69 Fed. Reg. at 49099.

*not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*²¹

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.²² In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²³ As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²⁴ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.²⁵ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁶ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁷ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁸ Once again, the Secretary has not acquiesced to this decision.

²¹ *Id.* (emphasis added).

²² 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²³ 72 Fed. Reg. at 47411.

²⁴ 746 F.3d 1102 (D.C. Cir. 2014).

²⁵ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁶ 863 F.3d 937 (D.C. Cir. 2017).

²⁷ *Id.* at 943.

²⁸ *Id.* at 943-945.

Providers' Request for EJR

The Providers explain 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.”²⁹ Accordingly, the Providers contend that the Board should grant their request for EJR.

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

Decision of the Board

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

Improper Inclusion of Previously Dismissed Providers on the Schedule of Providers

At the outset, the Board notes that the Schedule of Providers submitted by the Provider Representative with the EJR requests for Case Nos. 14-0369G and 14-3521G each *improperly* include a Provider that the Board previously has issued a determination denying the request to transfer that Provider to the respective group appeals. Specifically, the Board previously denied the transfers of Provider 36-0037, FYE 6/30/2006 to Case No. 14-3521G and Provider 20-0024, FYE 6/30/2007 to Case No. 14-0369G. Accordingly, these two Providers are not part of Case Nos. 14-0369G and 14-3521G and, as such, cannot be considered in this EJR request. The Board will address the Provider Representative’s failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

²⁹ Providers’ EJR request at 1.

Jurisdiction

The participants that comprise the group appeals within this EJR request have filed appeals involving fiscal years 2006, 2007, 2012 and 2013.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").³⁰ In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³¹

On August 21, 2008, new regulations governing the Board were effective.³² Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³³ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³⁴

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

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

³¹ *Bethesda*, 108 S. Ct. at 1258-59.

³² 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³³ 201 F. Supp. 3d 131 (D.D.C. 2016)

³⁴ *Id.* at 142.

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.³⁵ The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

The Board has determined that the participants involved with the instant EJR request are governed by the decision in *Bethesda* and CMS Ruling CMS-1727-R. The Providers that appealed from a revised NPR had an adjustment to Part C days issue. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.³⁶ The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR requests involve the 2006, 2007, 2012 and 2013 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).³⁷ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.³⁸ Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

³⁵ See 42 C.F.R. § 405.1889(b)(1) (2008).

³⁶ See 42 C.F.R. § 405.1837.

³⁷ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

³⁸ See 42 U.S.C. § 1395oo(f)(1).

- 2) Based upon the participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

Board Members Participating:

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

FOR THE BOARD:

3/29/2019

X Clayton J. Nix

Clayton J. Nix, Esq.

Chair

Signed by: Clayton J. Nix -A

Enclosures: Schedules of Providers

cc: Lorraine Frewert, Noridian (Electronic Mail w/Schedules of Providers)
Judith Cummings, CGS (Electronic Mail w/Schedules of Providers)
Cecile Huggings, Palmetto GBA (Electronic Mail w/Schedules of Providers)
Wilson Leong, (Electronic Mail w/Schedules of Providers)



DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Corinna Goron
Healthcare Reimbursement Services, Inc.
17101 Preston Road
Suite 220
Dallas, TX 75248

RE: *EJR Determination*

15-0549G HRS 2012 DSH SSI Fraction Medicare Managed Care Part C Days Group
15-0554G HRS 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

Dear Ms. Goron:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 5, 2019 request for expedited judicial review (EJR) for the appeals referenced above.¹ The Board's determination regarding EJR is set forth below.

Issue in Dispute:

The issue in these appeals is:

[W]hether Medicare Advantage Days ("Part C Days") should be removed from the disproportionate share hospital adjustment ("DSH Adjustment") Medicare fraction and added to the Medicaid Fraction.²

Statutory and Regulatory Background: Medicare DSH Payment

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

¹ The Board will be issuing EJR determinations in case numbers 15-0549G, 15-0554G, 17-0224G and 17-0223G which were included in the March 5, 2019 EJR request in separate correspondence.

² Providers' EJR request at 1.

³ See 42 U.S.C. § 1395ww(d)(1)-(5); 42 C.F.R. Part 412.

⁴ *Id.*

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

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

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

the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter¹⁰

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

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

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

⁵ See 42 U.S.C. § 1395ww(d)(5).

⁶ See 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

⁷ See 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.106(c)(1).

⁸ See 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

⁹ See 42 U.S.C. § 1395ww(d)(5)(F)(vi).

¹⁰ (Emphasis added.)

¹¹ 42 C.F.R. § 412.106(b)(2)-(3).

part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.¹²

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary¹⁴ stated that:

Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].¹⁵

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

¹² (Emphasis added.)

¹³ 42 C.F.R. § 412.106(b)(4).

¹⁴ of Health and Human Services.

¹⁵ 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).

¹⁶ *Id.*

With the creation of Medicare Part C in 1997,¹⁷ Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal year 2001-2004.¹⁸

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

... once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A
... *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicare fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . .*¹⁹

The Secretary purportedly changed her position in the Federal fiscal year (“FFY”) 2005 IPPS final rule, by noting she was “revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation.”²⁰ In response to a comment regarding this change, the Secretary explained that:

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

¹⁷ The Medicare Part C program did not begin operating until January 1, 1999. See P.L. 105-33, 1997 HR 2015, codified as 42 U.S.C. § 1394w-21 Note (c) “Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999” This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

¹⁸ 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

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

²⁰ 69 Fed. Reg. at 49099.

*beneficiaries in the Medicare fraction if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*²¹

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007 when the FFY 2008 IPPS final rule was issued.²² In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made “technical corrections” to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These “technical corrections” are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).²³ As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the “Part C DSH policy”).

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius (Allina I)*,²⁴ vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.²⁵ However, the Secretary has not acquiesced to that decision. More recently, in *Allina Health Services v. Price (Allina II)*,²⁶ the D.C. Circuit confirmed that the Secretary’s 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.²⁷ The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.²⁸ Once again, the Secretary has not acquiesced to this decision.

Providers’ Request for EJRB

The Providers explain 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

²¹ *Id.* (emphasis added).

²² 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

²³ 72 Fed. Reg. at 47411.

²⁴ 746 F. 3d 1102 (D.C. Cir. 2014).

²⁵ 746 F.3d at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) (“The Court concludes that the Secretary’s interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a “logical outgrowth” of the 2003 NPRM.”).

²⁶ 863 F.3d 937 (D.C. Cir. 2017).

²⁷ *Id.* at 943.

²⁸ *Id.* at 943-945.

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."²⁹ Accordingly, the Providers contend that the Board should grant their request for EJRs.

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

Decision of the Board

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

Improper Inclusion of Previously Dismissed Providers on the Schedule of Providers

At the outset, the Board notes that the Schedule of Providers submitted by the Provider Representative with the EJR requests for Case Nos. 15-049G and 15-0554G each *improperly* include the same Provider 36-0036 for FYE 12/31/2012 that the Board previously has issued a determination denying the request to transfer that Provider to the respective group appeals. Accordingly, this Provider is not part of Case Nos. 14-0369G and 14-3521G and, as such, cannot be considered in this EJR request. The Board will address the Provider Representative's failure to comply with Board Rules under separate cover pursuant to 42 C.F.R. § 405.1868.

Jurisdiction

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("Bethesda").³⁰ In that case, the Supreme Court concluded that a cost

²⁹ Providers' EJR Request at 1.

³⁰ 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The

report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.³¹

On August 21, 2008, new regulations governing the Board were effective.³² Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").³³ In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda*, the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.³⁴

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

For any participant that files an appeal from a revised Notice of Program Reimbursement (NPR) issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.³⁵ The Board notes that all participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.)

³¹ *Bethesda*, 108 S. Ct. at 1258-59.

³² 73 Fed. Reg. 30190, 30240 (May 23, 2008).

³³ 201 F. Supp. 3d 131 (D.D.C. 2016)

³⁴ *Id.* at 142.

³⁵ See 42 C.F.R. § 405.1889(b)(1) (2008).

Appeals Not Timely Filed

Pursuant to 42 C.F.R. § 405.1835(c)(1), the Medicare Contractor has 12 months from the date of receipt of the providers perfect cost report or amended cost report to issue a final determination of reimbursement. The Providers have 180 days after the expiration of the 12 month period for issuing a final determination to file an appeal with the Board.³⁶ In both Case Nos. 15-0549G and 15-0554G, Providers #9A Lima Memorial Hospital³⁷ and #12A MetroHealth System³⁸ filed their appeals 185 and 181 days, respectively, *after* the expiration of the 12-month period for the Medicare Contractor to issue their final determinations. The Board finds that these appeals of a *non-issuance* of a final determination were *not* timely filed as required by 42 C.F.R. § 405.1835(c)(2) and, hereby, dismisses these two Providers from Case Nos. 15-0549G and 15-0554G. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, these two Providers' request for EJR as it relates to their appeal from the *nonissuance* of an NPR for Case Nos. 15-0549G and 15-0554G is denied.³⁹ These two (2) Provider's *original NPR* appeal will remain pending in both cases.

Revised NPR Appeal

#10B Akron General Medical Center filed an appeal of its July 15, 2015 revised NPR which did not adjust the Part C Days issue as required for Board jurisdiction. The regulation, 42 C.F.R. § 405.1889 (2008), states that:

(a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in § 405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of . . . § 405.1835 . . . of this subpart are applicable.

(b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.

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

³⁶ 42 C.F.R. §405.1835(a)(3) the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for the issuance of the final contractor determination (as determined in paragraph (c)(1) of this section.

³⁷ Lima Memorial Hospital's cost report was received by the Medicare Contractor on May 30, 2013, and its appeal was received by the Board on December 1, 2014.

³⁸ MetroHealth System's cost report was received by the Medicare Contractor on May 29, 2013 and its appeal was received by the Board on November 26, 2014.

³⁹ See 42 C.F.R. § 405.1842(a).

Since the Akron General Medical Center's revised NPR did not adjust the Part C days issue as required by 42 C.F.R. § 405.1889, the Board finds that it lacks jurisdiction over the revised NPR and, hereby, dismisses the appeal of the revised NPR from Case Nos. 15-0549G and 15-0554G. Since jurisdiction over a provider is a requisite to granting a request for EJR, the Board hereby denies this Provider's request for EJR as it relates to the *revised* NPR from Case Nos. 15-0549G and 15-0554G. This Provider's *original* NPR appeal will remain pending in both cases.

Remaining Providers in Case Nos. 15-0549G and 15-0554G

The Board has determined that the remaining participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds \$50,000, as required for a group appeal.⁴⁰ The appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case. Based on the above, the Board finds that it has jurisdiction over the remaining Providers in the above-captioned appeals.

Board's Analysis Regarding the Appealed Issue

The appeals in these EJR request involves the 2012 cost reporting period. Thus, the appealed cost reporting period falls squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. The Board recognizes that, for the time period at issue in these requests, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).⁴¹ Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.⁴² Based on the above, the Board must conclude that it is otherwise bound by the regulation for purposes of this EJR request.

Board's Decision Regarding the EJR Request

The Board finds that:

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

⁴⁰ See 42 C.F.R. § 405.1837.

⁴¹ See generally *Grant Med. Ctr. v. Burwell*, 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).

⁴² See 42 U.S.C. § 1395oo(f)(1).

- 2) Based upon the remaining participants' assertions regarding 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B), there are no findings of fact for resolution by the Board;
- 3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and
- 4) It is without the authority to decide the legal question of whether 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (2008) codifying the Medicare Part C DSH policy adopted in the FFY 2005 IPPS final rule are valid.

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

Board Members Participating:

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

FOR THE BOARD:

3/29/2019

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS (Electronic Mail w/Schedules of Providers)
Wilson Leong, (Electronic Mail w/Schedules of Providers)