CMS Rulings

Department of Health and Human Services

Centers for Medicare & Medicaid Services

Ruling No.: CMS-1727-R Date: April 23, 2018

CMS Rulings are decisions of the Administrator that serve as precedent final opinions and orders and statements of policy and interpretation. They provide clarification and interpretation of complex or ambiguous statutory or regulatory provisions relating to Medicare, Medicaid, Utilization and Quality Control Peer Review, private health insurance, and related matters.

CMS Rulings are binding on all Centers for Medicare & Medicaid Services (CMS) components, on all Department of Health and Human Services (HHS) components that adjudicate matters under the jurisdiction of CMS, on all Medicare contractors, the Provider Reimbursement Review Board (PRRB), the Medicare Geographic Classification Review Board (MGCRB), and on all components of the Social Security Administration (SSA) that adjudicate matters under the jurisdiction of CMS. These decisions promote consistency in interpretation of policy and adjudication of disputes.

This Ruling states the policy of the Centers for Medicare & Medicaid Services concerning the CMS decision to follow the U.S. District Court for the District of Columbia's holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) for appeals of cost reporting periods that ended on or after December 31, 2008 and began before

January 1, 2016 that were pending or filed on or after April 23, 2018. For such appeals, assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought.

MEDICARE PROGRAM

Hospital Insurance (Part A)

JURISDICTION OF THE PROVIDER REIMBURSEMENT REVIEW BOARD AND OTHER ADMINISTRATIVE APPEALS TRIBUNALS OVER APPEALS OF SPECIFIC MATTERS THAT ARE SUBJECT TO A PAYMENT REGULATION OR POLICY THAT GIVES THE MEDICARE CONTRACTOR NO AUTHORITY OR DISCRETION TO MAKE PAYMENT IN THE MANNER THE PROVIDER SOUGHT

CITATIONS: Section 1878 of the Social Security Act (the Act) (42 U.S.C. 1395oo); 42 CFR Part 405, Subpart R.

BACKGROUND

1. Medicare Hospital Payments and Cost Reporting Requirements

Medicare pays short-term acute care hospitals under the inpatient prospective payment system (IPPS) on the basis of nationally applicable payment rates. The IPPS includes various adjustments and additional payments, such as outlier payments for certain extraordinarily lengthy or costly hospital patient stays.

Medicare administrative contractors (MACs) are private organizations that contract with the Secretary and act as his agent in making payment to Medicare providers of services. (In this Ruling, the terms "Medicare contractor" and "contractor" are used interchangeably to refer to the MAC.) A

provider must submit a cost report annually to the contractor, detailing the cost of items and services the provider furnished to Medicare beneficiaries.

2. Administrative and Judicial Review

Upon receipt of a provider's cost report, the contractor reviews or audits the cost report, makes any necessary adjustments to the provider's Medicare reimbursement for the cost reporting period, and issues a notice of program reimbursement (NPR) stating the contractor's final determination of the total amount of payment due the provider. The NPR can be appealed, and the contractor determination is final and binding unless it is revised on appeal or reopening.

Under section 1878(a)(1)(A), (a)(2), and (a)(3) of the Act (42 U.S.C. 1395oo(a)(1)(A), (a)(2), and (a)(3)) and 42 CFR 405.1835(a) of regulations, a provider may appeal to the PRRB a final contractor determination if: (1) the provider is "dissatisfied" with a final determination of the contractor or the Secretary; (2) the amount in controversy is at least $10,000; and (3) the provider files a hearing request within 180 days of its receipt of notice of the final determination of the contractor or the Secretary. The same jurisdictional requirements govern group appeals to the PRRB, except the amount in controversy requirement is at least $50,000. The same is true of provider appeals to contractor hearing officers under § 405.1811(a), except the amount in controversy requirement is at least $1,000 but less than $10,000.

The Secretary's delegate, the Administrator of CMS, may review certain PRRB decisions (42 U.S.C. 1395oo(f)(1)). The final decision of the PRRB or the Administrator is subject to judicial review under section 1878(f)(1) of the Act (42 U.S.C. 1395oo(f)(1)). A CMS reviewing official may review some contractor hearing officer decisions under § 405.1834, but there is no judicial review of contractor hearing officer decisions or CMS reviewing official decisions.

3. The Dissatisfaction Requirement for PRRB Jurisdiction

As explained previously, the PRRB has jurisdiction over appeals of certain final determinations if the provider is "dissatisfied" with the final determination of the contractor or the Secretary. CMS originally required a provider to make a specific claim for an item on its cost report as a prerequisite to appeal. Under that policy, a provider that did not claim an item on its cost report did not meet the dissatisfaction requirement. We did not permit a provider to "self-disallow" a specific item, even if the contractor had no authority or discretion to make payment in the manner the provider sought. (In self-disallowing an item, the provider submits a cost report that complies with Medicare payment policy for the item and then appeals the item to the PRRB; the contractor's NPR would not include any disallowance for the item, and the provider would effectively self-disallow the item.) This policy was not reflected in a regulation. In *Bethesda Hospital Ass'n v. Bowen*, 485 U.S. 399 (1988), the Supreme Court held that providers' failure to claim reimbursement in the cost report for more payment than a

regulation allowed did not mean they could not meet the dissatisfaction requirement for PRRB jurisdiction. The Court reasoned that it would be futile for a provider to seek payment that a contractor had no authority or discretion to make.

As a result of the *Bethesda* decision and subsequent litigation, CMS addressed the statutory dissatisfaction requirement in notice-and-comment rulemaking. The final rule, which was published in the May 23, 2008 Federal Register (73 FR 30194 through 30200 and 30249 and 30250), indicated that a provider must preserve its right to claim dissatisfaction by including one of two types of a cost report claim for the item under appeal. First, under 42 CFR 405.1835(a)(1)(i), a provider must claim reimbursement for the item in its cost report if it is seeking reimbursement that it believes is in accordance with Medicare policy. Second, under 42 CFR 405.1835(a)(1)(ii), if the provider is seeking reimbursement that it believes may not be allowed under Medicare policy (for example, where the contractor does not have the authority or discretion to make payment in the manner the provider seeks), then the provider must self-disallow the item by filing the applicable parts of its cost report under protest. But providers should not self-disallow items if they do not have a good faith belief that the items may not be allowable under Medicare payment policy (see 73 FR 30196). Providers also sometimes file a cost report under protest out of concern that a cost report claim for reimbursement of a non-allowable item might raise program integrity concerns. Section 405.1835(a)(1)(ii)'s self-disallowance requirement for PRRB jurisdiction over non-allowable items was effective for cost reporting periods ending on or after December 31, 2008. The May 2008 rule established a similar dissatisfaction requirement for contractor hearing officer jurisdiction at 42 CFR 405.1811(a)(1)(ii).

4. November 13, 2015 Final Rule: Changing the Requirement of an Appropriate Cost Report Claim from PRRB Jurisdiction Rule to a General Substantive Requirement for Payment

In a final rule published in the November 13, 2015 Federal Register (80 FR 70555 through 70565 and 70603 and 70604), we changed the requirement of an appropriate cost report claim from a jurisdiction rule to a general substantive requirement for payment, effective for cost reporting periods beginning on or after January 1, 2016. As a result, the cost report claim requirements of the PRRB and contractor hearing officer jurisdiction regulations at 42 CFR 405.1835(a)(1) and 405.1811(a)(1) that became effective in 2008 were eliminated and do not affect cost reporting periods beginning after December 31, 2015.

5. Decision in *Banner Heart Hospital v. Burwell* (D.D.C. August 19, 2016)

In *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016) ("*Banner*"), the plaintiff hospitals claimed Medicare outlier payments in their fiscal year ending December 31, 2008 cost reports in accordance with applicable outlier payment rules and policies, but they did not claim or self-disallow any additional outlier payments as protested amounts in the cost reports. After the

hospitals were paid in accordance with the outlier regulations, they appealed to the PRRB and requested expedited judicial review (EJR) to challenge the validity of the outlier payment regulations. Applying the 2008 final rule, the PRRB denied the hospitals' EJR request, finding that it lacked jurisdiction over the providers' regulatory challenge because of the hospitals' failure to self-disallow the non-allowable outlier payments.

In the *Banner* decision, the district court held that, despite the hospitals' failure to comply with the self-disallowance regulation, the Supreme Court's decision in *Bethesda Hospital* establishes that the PRRB had jurisdiction over the hospitals' challenge to a payment regulation, as a cost report reimbursement claim for additional outlier payments would have been futile because the outlier regulations gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought. More specifically, the *Banner* court concluded that, given the Supreme Court's interpretation of section 1878(a)(1)(A) of the Act (42 U.S.C. 1395oo(a)(1)(A)) in *Bethesda Hospital*, the 2008 self-disallowance regulation may not be applied to appeals raising a legal challenge to a payment regulation or other policy that the Medicare contractor cannot address. The court did not declare any other application of the self-disallowance regulation unlawful and did not address the 2015 final rule.

CMS continues to believe that the self-disallowance regulation, 42 CFR 405.1835(a)(1)(ii), is a reasonable interpretation of the dissatisfaction requirement for PRRB jurisdiction in section 1878(a)(1)(A) of the Act (42 U.S.C. 1395oo(a)(1)(A)). Nonetheless, we did not appeal the *Banner* decision, and any provider may file lawsuits in the U.S. District Court for the District of Columbia. Accordingly, CMS has decided to apply the holding of the district court's *Banner* decision to certain similar administrative appeals.[1]

IMPLEMENTATION OF THIS RULING

Implementation of this Ruling involves the PRRB or other reviewing entity (as defined in 42 CFR 405.1801(a)) taking some of the following five steps in order.

First: Determining Applicability of Ruling

As a precedent final opinion or order and a statement of policy or interpretation, *see* 42 CFR 401.108, this Ruling applies only to administrative appeals pending on or after, or appeals initiated on or after, the effective date of the Ruling, which is April 23, 2018. Accordingly, the PRRB or other

1 CMS's decision to follow the holding in the district court's *Banner* decision is not an indication that any adverse decision or ruling, whether by the U.S. Court of Appeals for the District of Columbia Circuit or by the U.S. District Court for the District of Columbia, on a Medicare issue automatically necessitates a change in Medicare policy. *See generally United States v. Mendoza*, 464 U.S. 154, 154 (1984) (holding that the United States may not be barred from litigating an issue that was adjudicated against it in an earlier lawsuit brought by a different party).

reviewing entity, as applicable, must determine whether the administrative appeal in question was pending or initiated on or after the April 23, 2018 effective date of the Ruling, in addition to determining whether the cost reporting period under appeal ended on or after the December 31, 2008 and began before January 1, 2016. If the administrative appeal in question was pending or initiated on or after the April 23, 2018 effective date of the Ruling, and the cost reporting period under appeal comes within the above-described 7-year period, the reviewing entity then should proceed to the Second implementation step.

Second: Determining Allowability of Specific Item Under Appeal

The PRRB or other reviewing entity, as applicable, must determine whether the specific item under appeal was subject to a regulation or other payment policy that bound the contractor and left it with no authority or discretion to make payment in the manner sought by the provider, thereby rendering futile a cost report reimbursement claim that is not in accordance with the payment regulation or other policy for the specific item at issue. Payment policies are included in the regulations, manual provisions, and other subregulatory guidance (for example, CMS letters to the Medicare contractors). Also, the contractors sometimes make policy determinations. Policy determinations are usually made in writing but oral notification is sometimes provided.

There might be situations where the PRRB or other reviewing entity is unsure whether the specific item under appeal 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. In those situations, the reviewing entity may use any discretion it has to take evidence and legal argument on this question. In any event, after the PRRB or other reviewing entity makes this determination, the reviewing entity then should proceed to the Third or Fourth implementation step, as applicable.

Third: Determining Jurisdiction If Item Deemed Allowable

If the PRRB or other reviewing entity determines that the Medicare contractor actually had the authority or discretion to make payment for the specific item at issue in the manner sought by the provider on appeal, and if the provider's cost report claimed reimbursement for the allowable item in the manner sought by the provider on appeal, then the provider has met the dissatisfaction jurisdictional requirement in § 405.1811(a)(1)(i) or § 405.1835(a)(1)(i), as applicable. The reviewing entity should then apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures. However, if the provider's cost report did not claim reimbursement for the allowable item in the manner sought by the provider on appeal, and the provider has not demonstrated a good faith belief that the item was not allowable, *see* (73 FR 30196), then the provider has not met the dissatisfaction jurisdictional

requirement in § 405.1811(a)(1) or § 405.1835(a)(1), as applicable. The reviewing entity should then issue a jurisdictional dismissal decision under § 405.1814(c) or § 405.1840(c), as applicable. If the provider's cost report did not claim reimbursement for the allowable item in the manner sought by the provider on appeal, but the provider has demonstrated a good faith belief that the item was not allowable, then the provider has met the dissatisfaction jurisdictional requirement. The reviewing entity should then apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures. We believe a provider would rarely be able to demonstrate a good faith belief that an item is not allowable when that item is actually allowable under a Medicare payment regulation or other policy.

Fourth: Determining Jurisdiction If Item Deemed Non-Allowable

If the PRRB or other reviewing entity, as applicable, determines that the specific item under appeal 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 on appeal, then the pertinent reviewing entity shall not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable), to the specific non-allowable item under appeal; instead, the reviewing entity should apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures.

Fifth: Self-Disallowing Non-Allowable Items Despite Ruling

As described previously, providers sometimes file a cost report under protest out of concern that a cost report claim for reimbursement of an item deemed non-allowable might raise program integrity questions. Notwithstanding the agency's decision in this Ruling to apply the holding of the district court's *Banner* decision regarding the self-disallowance regulation to certain similar administrative appeals, a provider still may elect to self-disallow a specific item deemed non-allowable by filing the pertinent parts of its cost report under protest in accordance with the procedures set forth in section 115 of the Provider Reimbursement Manual (PRM), Part 2. However, if the PRRB or other reviewing entity were to determine that, despite the provider's self-disallowance of the specific item under appeal, the Medicare contractor actually had the authority or discretion to make payment for the specific item at issue in the manner sought by the provider on appeal and the provider did not demonstrate a good faith belief that such item is not allowable, then the reviewing entity shall apply the Third implementation step for this Ruling.

RULING

First, it is CMS's Ruling that, for an appeal of a cost reporting period that ends on or after December 31, 2008 and begins before January 1, 2016, where such appeal was pending or initiated on or after the April 23, 2018 effective date of this Ruling, the self-disallowance requirement for PRRB jurisdiction in 42 CFR 405.1835(a)(1)(ii) shall not be applied to a provider's appeal of a specific item if the provider had a good faith belief that claiming reimbursement for such item in the cost report would be futile because the item was subject to a regulation or other payment policy that bound the Medicare contractor and left the contractor with no authority or discretion to make payment in the manner sought by the provider.

Second, it is also CMS's Ruling that, for an appeal of a cost reporting period that ends on or after December 31, 2008 and begins before January 1, 2016, where such appeal was pending or initiated on or after the April 23, 2018 effective date of this Ruling, the self-disallowance requirement for contractor hearing officer jurisdiction in 42 CFR 405.1811(a)(1)(ii) shall not be applied to a provider's appeal of a specific item if the provider had a good faith belief that claiming reimbursement for such item in the cost report would be futile because the 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.

Third, it is CMS's further Ruling that, in order to give full force and effect to the forgoing First and Second CMS Rulings, neither the PRRB nor any other reviewing entity (as defined in 42 CFR 405.1801(a)) shall deny jurisdiction, decline to exercise jurisdiction, impose a sanction, or take any other action adverse to a provider's appeal of a specific item where the item was non-allowable (or the provider had a good faith belief that the item was non-allowable) because of 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, based on a determination by the PRRB or other reviewing entity, as applicable, that the provider failed to comply with the self-disallowance jurisdictional requirement (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) with respect to the specific item under appeal.

Fourth, it is CMS's further Ruling that if a provider appeals a specific item that it believes is non-allowable (for example, because the provider believes that the contractor does not have the authority or discretion to award the reimbursement sought by the provider, thereby rendering futile a cost report reimbursement claim that is not in accordance with a payment regulation or other policy for the specific item at issue), then notwithstanding the forgoing First and Second CMS Rulings, the provider still may elect to self-disallow such specific item by filing the pertinent parts of its cost report under protest in accordance with the procedures set forth in section 115 of the PRM, Part 2. However, if the PRRB or other reviewing entity, as applicable, determines that, despite the provider's self-

disallowance of the specific item under appeal, the Medicare contractor actually had the authority or discretion to make payment for the specific item at issue in the manner sought by the provider and the provider did not demonstrate a good faith belief that such item is not allowable, then if the cost reporting period under appeal ended on or after December 31, 2008 and began before January 1, 2016, the PRRB or other reviewing entity shall apply the Third implementation step of this Ruling.

Fifth, it is also CMS's Ruling that, under 42 CFR 405.1801(a) and 405.1885(c)(1) and (2), this Ruling is not an appropriate basis for the reopening of any final determination by a Medicare contractor or the Secretary or of any decision by the PRRB or other reviewing entity. Accordingly, it is hereby held that the Medicare contractors and the reviewing entities may not reopen any determination or decision with respect to the question of whether application of the self-disallowance jurisdictional requirement in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable, is foreclosed by any provision of this CMS Ruling.

Sixth, it is CMS's further Ruling that, under 42 CFR 401.108, this Ruling is a final precedent opinion and order and a statement of policy and interpretation that addresses two procedural rules (42 CFR 405.1835(a)(1)(ii) and 42 CFR 405.1811(a)(1)(ii)), and thus this Ruling is not subject to public notice-and-comment rulemaking procedures under section 1871(a)(1), (a)(2) and (b)(1) of the Act (42 U.S.C. 1395hh(a)(1), (a)(2), and (b)(1)) and the Administrative Procedure Act, 5 U.S.C. 551(4) through (7), and 553. The Ruling is also exempted from public notice-and-comment rulemaking procedures under the Administrative Procedure Act, 5 U.S.C. 553(b)(3)(A); but if this Ruling were found to require public notice-and-comment rulemaking procedures, then, in accordance with section 1871(b)(2)(C) of the Act (42 U.S.C. 1395hh(b)(2)(C)) and the Administrative Procedure Act, 5 U.S.C. 553(b)(3)(B), there is good cause to issue and apply this Ruling without public notice-and-comment rulemaking procedures because such procedures are impracticable, unnecessary, and contrary to the public interest in the orderly processing of certain administrative appeals that are similar to the appeals at issue in the *Banner* lawsuit.

Seventh, it is also CMS's Ruling that, under 42 CFR 401.108, this Ruling is a final precedent opinion and order and a statement of policy and interpretation that does not give rise to any putative retroactive rulemaking issues; but if this Ruling were deemed to implicate potential retroactive rulemaking issues, then, in accordance with section 1871(e)(1)(A)(ii) of the Act (42 U.S.C. 1395hh(e)(1)(A)(ii)), the issuance and retroactive application of this Ruling is necessary to serve the public interest in the orderly processing of certain administrative appeals that are similar to the appeals at issue in the *Banner* lawsuit.

EFFECTIVE DATE

This Ruling is effective April 23, 2018.

Dated: 4/23/18

Seema Verma,
Administrator,
Centers for Medicare & Medicaid Services.