DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Electronic Delivery

Jonathan Werne
St. Dominic Health Services, Inc.
969 Lakeland Drive
Jackson, MS 39216

RE: ***Board Own Motion Expedited Judicial Review Determination***
13-3152 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2006
13-2937 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2007
14-0220 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2008
14-0263 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2009
14-4048 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2010
15-2511 – St. Dominic-Jackson Memorial Hospital (25-0048) FYE 12/31/2011

Dear Mr. Werne:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced appeals involving the Provider, St. Dominic-Jackson Memorial Hospital (Provider No. 25-0048). Following this review, as required by 42 C.F.R. § 405.1842(c), the Board notified the Provider on November 21, 2019 that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate for the above referenced cases. Both the Provider and Federal Specialized Services ("FFS"), on behalf of the Medicare Contractor, have submitted comments as to whether the Board is without the authority to decide the following legal question[1]:

> Whether the CMS improperly included Medicare Part C Days in the numerator of the Medicare/SSI fraction and improperly excluded Medicare Part C Days from the numerator and denominator of 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] Both Provider's and FSS's comments were received on December 20, 2019.
[2] Request for Hearing, Issue Statement, at Ex. 3 (Aug. 30, 2013), 13-3152; *See also* 13-2937, 14-0220, 14-0263, 14-4048, 15-2511.
[3] *See* 42 U.S.C. § 1395ww(d)(l)-(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:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[10]

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

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

> [T]he 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.l06(c)(l).
[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 Secretary[14] 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]

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[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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[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 beneficiaries in the Medicare fraction . . . . if the beneficiary*

[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.

> *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"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[24]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[25] 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.[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

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[21] *Id.* (emphasis added).
[22] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[23] *Id*. at 47411.
[24] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[25] 746 F. 3d 1102 (D.C. Cir. 2014).
[26] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[27] 863 F.3d 937 (D.C. Cir. 2017).
[28] *Id*. at 943.

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.

Provider's Response to Board's Request for Comments

The Provider contends that CMS improperly included Medicare Part C days in the numerator of the Medicare/SSI fraction and improperly excluded Medicare Part C days from the numerator and denominator of the Medicaid fraction. As the appeals involved the 2006 through 2011 cost reporting periods, the Part C days issue for these periods have been the subject of considerable litigation, resulting in relevant judicial decisions including the Supreme Court's recent decision in *Azar v. Allina Health Services*, 139 S. Ct. 1804 (2019).[30] The Provider notes that, notwithstanding the fact that the Supreme Court's decision supports its position in these cases, CMS has not published any guidance on how the decision will be implemented. As there are no factual disputes and CMS has not acquiesced to the decision in *Allina I*, the Provider believes that the Board is without the authority to decide the legal question and, therefore, considers EJR to be proper.[31]

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[32] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[33] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

[29] *Id.* at 943-945.
[30] Provider's Response to Own Motion for Expedited Judicial Review (Dec. 20, 2019).
[31] *Id.*
[32] 69 Fed. Reg. at 49,099.
[33] *Allina* at 1109.

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 addressed in this EJR determination have filed appeals involving fiscal years 2006 through 2011.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[34] 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.[35]

On August 21, 2008, new regulations governing the Board were effective.[36] 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 before the D.C. District Court in *Banner Heart Hosp. v. Burwell* ("*Banner*").[37] 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 D.C. 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.[38]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began

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[34] 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.).
[35] *Bethesda*, 108 S. Ct. at 1258-59.
[36] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[37] 201 F. Supp. 3d 131 (D.D.C. 2016).
[38] *Id.* at 142.

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 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.[39] The Board notes that the participant has one appeal stemming from a revised NPR included within this EJR request (FY 2006) which was issued after August 21, 2008.

The Board has determined that the participants' appeals involved with the instant EJR requests are governed by the decision in *Bethesda* and CMS-1727R given that both the Providers and the MACs are otherwise bound by the DSH Part C policy at issue because it was codified into regulation and remains in effect. The Provider filed its appeal for FY 2006 from a revised NPR which adjusted the SSI percentage to include Part C Days, which satisfies the requirements of 42 C.F.R. § 405.1889 for Board jurisdiction. The Provider appealed from an original NPR in FYs 2007-2011. In addition, the Provider's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[40] and that 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.

Accordingly, the Board finds that it has jurisdiction for the Provider in the referenced appeals.

Board's Analysis Regarding the Appealed Issue

The appeals in these cases involve the 2006 through 2011 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 periods 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 Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[42]

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[39] See 42 C.F.R. § 405.1889(b)(1) (2008).
[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).

Board's Decision Regarding the EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the Provider in the individual appeals is entitled to a hearing before the Board;

2) Based upon the Provider's 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) (2011) 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) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Each of these appeals contains additional issues under dispute in these cases, outside the scope of this EJR determination, and these cases will remain open.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA, CPC-A
Susan A. Turner, Esq.

For the Board:

1/3/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.
Justin Lattimore, Novitas Solutions, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ms. L. Rene Shannon
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4400 Golf Acres Dr., Bldg. J, Ste. A
Charlotte, NC 28208

Ms. Laurie Polston, Appeals Lead
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: ***Untimely Filing of an Appeal***
Carolinas Healthcare System – Blue Ridge (Prov No. 34-0075)
FYE 12/31/2008
Case No. 19-2763

Dear Ms. Shannon and Ms. Polston:

The above-captioned appeal was filed with the Provider Reimbursement Review Board ("Board") and is based on the Notice of Program Reimbursement ("NPR") dated March 19, 2019. As set forth below, the Board is dismissing this case due to the Provider's failure to file a timely appeal.

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

Board Rule 4.3.1 states, in part:

> The date of receipt of a contractor final determination is presumed to be 5 days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. *See* 42 C.F.R. § 405.1801(a)(1)(iii).
>
> The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 4.5.A states, in part:

> Timely filing is determined based on the date of receipt by the Board. The date of receipt is presumed to be:
>
> A. The date submitted to OH CDMS as evidenced by the Confirmation of Correspondence generated by the system.

The NPR, the final determination in dispute, is dated March 19, 2019. Pursuant both to the Board rules and regulations cited above, a Provider is presumed to have received its NPR five (5) days after the issuance of the NPR which was March 24, 2019. In the subject appeal, 180 days from March 24, 2019 is Friday, September 20, 2019. However, the Provider filed the subject appeal on September 26, 2019, six (6) days

after the 180-day deadline (*i.e.*, 6 days after Friday, September 20, 2019). As a result, the Board concludes that the subject appeal was not timely filed and hereby dismisses the appeal. 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:

1/3/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Palmetto GBA c/o Nat. Gov. Servs, Inc.
Laurie Polson
MP: INA 101-AF42
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Indianapolis, IN 46206-6474

RE: ***Jurisdictional Decision***
Forsyth Memorial Hospital (Prov. No. 34-0014)
FYE 12/31/2008
Case No. 14-1052

Dear Mr. Ravindran and Ms. Polson,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's jurisdictional challenge. The pertinent facts of the case, the Parties' positions and the Board's jurisdictional determination are set forth below.

Background

On November 26, 2013, the Provider submitted a request for hearing with ten issues based on a Notice of Program Reimbursement ("NPR") dated June 7, 2013. Later, the Provider requested to add the following issues to its appeal:

- Inpatient Rehabilitation Facility ("IRF") Low Income Patient ("LIP") component to DSH SSI Provider Specific;
- Medicaid Eligible Days;
- Medicare Managed Care Part C days; and
- DSH Dual Eligible Days issues.

The Provider transferred a number of issues to various group appeals.

On December 22, 2014, the Medicare Contractor submitted its jurisdictional challenge on over the DSH SSI Provider Specific issue, DSH Medicaid Eligible Days issue, Rural Floor Budget Neutrality Adjustment ("RFBNA") and the IRF LIP component of the above listed issues. On January 20, 2015, the Provider submitted its Jurisdictional Response. On December 4, 2019, the Medicare Contractor submitted an update to its Jurisdictional Challenge.

Medicare Contractor's Position

DSH SSI (Provider Specific)

The Medicare Contractor contends that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. The Provider has not requested to use its fiscal year end to recalculate the SSI percentage.[1]

The Medicare Contractor contends that the Provider's appeal of the SSI Realignment issue is premature as it did not make a determination with respect to the SSI Realignment issue. To date, the Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). The Medicare Contractor requests that the Board dismiss this issue consistent with recent jurisdictional decisions. [2]

The Medicare Contractor included an update to its challenge to the SSI data accuracy component of Issue 1 in its Jurisdictional Challenge dated December 4, 2019. The Medicare Contractor contends that the portion of Issue 1 related to SSI data accuracy should be dismissed because it is duplicative of Issue 2, DSH SSI Systemic Errors, which was transferred on August 11, 2014 to Group Case 14-0632GC, QRS Novant 2008 DSH SSI Percentage Systemic CIRP Group.[3]

*The RFBNA **and** IRF LIP Component Issues*

The Medicare Contractor states that it challenged both of these issues in its jurisdictional challenge dated December 19, 2014. However, it now maintains that the Provider abandoned these issues in the Provider's Final Position Paper dated September 13, 2019.[4]

Provider's Position

DSH SSI (Provider Specific)

The Provider argues that it is not only addressing a realignment of the SSI percentage, but is addressing the various errors of omission that do not fit into the "systemic errors" category. The Provider states that it can submit data to prove its SSI percentage is understated once it receives Medicare Provider Analysis and Review ("MedPAR") data.[5]

[1] Medicare Contractor's jurisdictional challenge at 11. (Dec. 19, 2014)
[2] Medicare Contractor's jurisdictional challenge at 12-13. (Dec. 19, 2014)
[3] Medicare Contractor's jurisdictional challenge at 3. (Dec. 4, 2019)
[4] Medicare Contractor's jurisdictional challenge at 2. (Dec. 4, 2019)
[5] Provider's jurisdictional response at 4 (Jan. 16, 2015).

Analysis and Recommendation:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination. The jurisdictional issue presented here is whether or not this hospital has preserved its right to claim dissatisfaction with the amount of Medicare payment. "A provider. . . has a right to a Board hearing . . . only if – (1) the provider has preserved its right to claim dissatisfaction…..by…..[i]ncluding a claim for specific item(s) on its cost report…or…self-disallowing the specific item(s) by…..filing a cost report under protest…..[6]

DSH SSI (Provider Specific)

The Provider's appeal of the SSI Provider Specific issue is based on the contention that the SSI percentage published by CMS was incorrectly computed because CMS failed to include all patients entitled to SSI benefits in the Provider's DSH calculation. The Board finds that this issue is duplicative of the SSI Percentage Systemic errors issue that the Provider transferred to a group appeal, Case No. 14-0632GC - QRS Novant 2008 DSH SSI Percentage Systemic Errors CIRP Group by a request dated August 11, 2014. The Providers in that CIRP Group challenge their SSI percentages because of disagreement over how the SSI percentage is calculated and contend that CMS has not properly computed the SSI percentage because it failed to include all patients entitled to SSI benefits in the calculation.[7] Pursuant to Board Rule 4.6.1, "A provider may not appeal an issue from a single determination in more than one appeal." Therefore, the Board finds that the SSI Provider specific issue is duplicative of the issue the Provider is appealing in the group appeal and hereby dismisses this aspect of the SSI Provider specific issue.

In its SSI Provider Specific issue statement, the Provider also asserts that it "preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period." Under 42 C.F.R. § 412.106(b)(3), "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 a written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for purposes of appeal. Additionally, even if the Provider has requested (and received) a realignment of its SSI percentage, that is not a final determination from which the Provider can appeal, or with which the Provider can be dissatisfied, as required by 42 C.F.R. § 405.1835(a). Therefore, the Board finds that it does not have jurisdiction over the realignment portion of the Provider's SSI Provider Specific issue.

[6] 42 C.F.R. § 405.1835(a).
[7] The Board notes that it has been six (6) years since the Provider filed its appeal and that, even at this late date, the Provider has not presented any evidence that suggests that the issues are not duplicative.

Rural Floor Budget Neutrality Adjustment and the Inpatient Rehabilitation Facility Low Income Patient component

The Provider's final position paper submitted on September 17, 2019 very clearly identified only the DSH SSI Provider Specific, DSH Medicaid Eligible Days and DSH Labor and Delivery Room Days[8] issues as remaining in the subject appeal.

PRRB Rule 27.2 specifically lays out the content that must be included in the final position paper. It states, "The final position paper should address **each remaining issue**" and should include details such as the reimbursement impact, procedural history, and statement of facts. As the Provider did not include the RFBNA and LIP issues in its final position paper, the Board finds that these issues have been abandoned and are no longer pending in the subject appeal.

* * * * *

In conclusion, the Board finds that it does not have jurisdiction over the SSI Provider Specific issue and that the Provider abandoned the RFBNA and LIP issues in the subject appeal. Case No. 14-1052 remains open for the sole remaining issue – the DSH Medicaid Eligible Days issue.

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

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:

1/3/2020

X Clayton J. Nix

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

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

[8] The Board notes that the Provider transferred the DSH Labor and Delivery Room Days issue to Case No. 14-0607GC on August 14, 2014. Therefore, this issue is no longer pending in the subject appeal.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Sven Collins, Esq.
Squire Patton Boggs (US) LLP
1801 California St., Ste. 4900
Denver, CO 80202

RE: ***Denial of Expedited Judicial Review Request***
Patton Boggs Part C Days Medicaid and Medicare/SSI Fraction Groups
Case Nos. 13-3518GC, *et al*. (*see* attached case list)

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' requests for expedited judicial review ("EJR") which were received on December 13, 2019, for the above-referenced twelve (12) group appeals. As explained below, the Board denies these EJRs because the format in which the jurisdictional documents were submitted fails to comply with the Board Rules. This noncompliance affects the 30-day period to respond to a request for EJR.[1]

BOARD DENIAL

The Providers filed these requests for EJR for the above-captioned twelve (12) groups, each consisting of multiple providers. Included in the electronic filings were the EJR Request, the Schedule of Providers, and certain associated jurisdictional documents.

As explained below, the Board Rules require the Schedule of Providers and the supporting documentation to be filed ***in hard copy***. Thus, the documents must be filed ***in hard copy*** prior to (or concurrent with) the EJR being requested, in order for the Board to determine if jurisdictional requirements are met. If the Provider continues to wish to pursue the EJR, the Board is requiring that the Group Representative to refile the Schedule of Providers and associated documentation ***in hard copy*** (as prescribed by the Board's Rules) for each of the above referenced appeals and to notify the Board with the Schedules that the EJR request is renewed.

42 C.F.R. § 405.1835(a) requires that, prior to determining if EJR is appropriate, the Board must first establish it has jurisdiction over the matter at issue. As such, the Board will not render a jurisdictional determination in this case until the Board receives a Schedule of Providers and the associated jurisdictional documentation both complies with the Board's Rules and is complete. To facilitate your compliance, the Board has annotated below the error that it is requesting that

[1] *See* 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii) and (e)(3)(ii).

you correct in your ***hard copy*** resubmission of the Schedule of Providers and associated documentation. The Board appreciates your time and effort to organize the information and documents in compliance with Board Rules as this organization essential to the Board's timely review of jurisdiction for each provider included in the group.

Deficient Filing Requirement—Hard Copy Requirement per Board Rule 20.1

A. *Rule Description.*— Within 60 days of the full formation of the group (*see* Board Rule 19), the group representative must prepare a schedule of providers (Model Form G at Appendix G) and supporting jurisdictional documentation that demonstrates that the Board has jurisdiction over the providers named in the group appeal (*see* Board Rule 21).

- The schedule of providers and jurisdictional documents is to be sent to the Board.
- A copy of the schedule and all documentation is to be sent to the Lead Medicare Contractor.
- An additional copy of only the schedule of providers, without the accompanying jurisdictional documents, is to be sent to the Appeals Support Contractor.

B. *Errors in Your Submission to be Corrected.*—The commentary to Rule 20.1 includes the following:

> Although the PRRB is moving to its electronic case management system, it will take additional time to fully populate the existing participants in the group cases. Therefore, ***until further notice****, the Board is still requiring* ***a hard copy*** *of the Schedule of Providers and its accompanying supporting documentation.*

Accordingly, the Schedule of Providers needs to be resubmitted in hard copy in compliance with Board Rule 20.1.[2]

CONCLUSION

As the schedules or Providers submitted for the EJR requests are out of compliance with the Board Rules, the Board hereby denies the request for EJR for the above-captioned twelve (12) group cases. ***Hard copies*** of the Schedules of Providers (with the associated jurisdictional

[2] *See* 42 C.F.R. § 405.1837(e)(2) (specifying that a provider request for EJR cannot be considered complete unless it includes, among other things, "[a]ll of the information and documents *found necessary by the Board* for issuing a decision in accordance with paragraph (f) of this section" (emphasis added)); 42 C.F.R. §§ 405.1868(a) and (b) (specifying that the Board shall has full power and authority to make rules and establish procedures and to take appropriate actions in response to the failure of a party to comply with Board Rules).

documents) must be submitted simultaneous with notification that the previous EJR requests are renewed.

Sincerely,

1/7/2020

X Clayton J. Nix

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

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

Appendix A

13-3518GC	Patton Boggs 2009 DSH Medicare Part C/Part A Days Medicaid Fraction - Lee Memorial CIRP Group
13-3521GC	Patton Boggs 2009 DSH Medicare Part C/Part A Days Medicare Fraction - Lee Memorial CIRP Group
13-3856GC	Patton Boggs 2011 Lee Memorial Medicare Part C/Part A Days Medicaid Fraction CIRP
13-3857GC	Patton Boggs 2011 Lee Memorial Medicare Part C/Part A Days Medicare Fraction CIRP
14-0909GC	Patton Boggs 2007- 2008 DSH Lee Memorial-Medicaid Fraction-Medicare Part C/Part A CIRP Group
14-0911GC	Patton Boggs 2007- 2008 Lee Memorial Medicare Fraction Part C/Part A CIRP Group
14-4021GC	Squire Patton Boggs 2012 DSH Medicare Part C Days/Medicaid Fraction - Lee Memorial CIRP Group
14-4022GC	Squire Patton Boggs 2012 DSH Medicare Part C Days/Medicare Fraction - Lee Memorial CIRP Group
14-4281GC	Squire Patton Boggs 2010 DSH Medicare Part C/Part A Days Medicaid Fraction - Lee Memorial NPR CIRP Group
14-4282GC	Squire Patton Boggs 2010 DSH Medicare Fraction Part C/Part A Days Medicare - Lee Memorial NPR CIRP Group
15-3367GC	Squire Patton Boggs - Lee Memorial 2013 Medicare Fraction Part C Days CIRP
15-3368GC	Squire Patton Boggs - Lee Memorial 2013 DSH Medicaid Fraction Part C Days CIRP

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21207
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Via Electronic Delivery

Leslie Demaree Goldsmith, Esq.
Baker Donelson
100 Light Street
Baltimore, MD 21202

RE: ***EJR Determination-Baker Donelson DGME Appeals***
18-1838GC Premier Health Partners CY 2015 DGME Penalty to FTE Count Group
18-1875G Baker Donelson CY 2009 DGME Penalty to FTE Count Group
19-0398GC Ohio State Health System CY 2015 DGME Penalty to FTE Count Group
19-0680G Baker Donelson CY 2014 DGME Penalty to FTE Count Group
19-0691GC Univ. of Rochester CY 2014 DGME Penalty Group
19-2185GC Univ. of PA Health System 2013 DGME Penalty to FTE Count Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' December 12, 2019 request for expedited judicial review ("EJR") (received December 13, 2019). The decision of the Board is set forth below.

The Providers in these cases are challenging:

> [T]he validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(d). The regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of weighting factors. 42 U.S.C. § 1395ww(h)(4)(F). The effect of the . . . regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period ("IRP"), and it prevents Providers from claiming their full unweighted FTE caps authorized by statute. . . .[1]

[1] Providers' EJR requests at 1.

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

These appeals concern the first component of the DGME payment calculation—the resident FTE count.

A hospital's "resident FTE count" for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting

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[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.

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[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish *new* programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's *reduced cap*.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE

[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."

> residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute at 42 U.S.C. § 1395ww(h) for several reasons. First, the regulation creates a weight FTE cap. The Providers believe that the statute plainly requires the Secretary to determine the cap "before the application of weighting factors," which is an unweighted cap.[17] The Secretary instead determines a weighted FTE cap for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE (UCap/UFTE) = WCAP, is applied to the weighted FTE count in the current year, which creates a second FTE cap that is an absolute limit on the number of FTEs that can go into the DGME payment calculation. This second cap is determined after the application of the weighting factors to fellows in the current year, which the Providers allege violates Congress' directive to determine the cap before the application of the weighting factors.

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[14] 42 C.F.R. § § 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).

Second, the Secretary's weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The downward impact on the FTE count increases as a hospital trains more residents beyond the IRP.

Third, the Providers assert, the regulation imposes a weighting factor that reduces the FTE time by more the 0.5 contrary to the statute. In these cases, all of the Providers are over their FTE caps and train residents that are beyond the IRP and are prevented from reaching their full FTE caps due to the Secretary's regulation. The Providers suffered a downward payment adjustment that is greater than may be imposed by the statutory 0.5 weighting factor. By establishing the cap based on the hospital's unweighted FTE count for 1996, Congress entitled the Providers to claim FTEs up to that cap. The Providers contend that the regulation renders this impossible for these Providers simply because they trained residents who are beyond the IRP. The Providers assert that the regulation, 42 C.F.R. § 412.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and is, therefore, invalid.

Parties Comments Regarding Whether the Groups Contain a Single Issue

In two of the cases[18] included in the EJR request, the Medicare Contractor, CGS Administrators, posited that the current, prior and penultimate weighted DGME counts are different components of the DGME calculation. The Medicare Contracter points out that pursuant to Board Rule 8.1[19] each contested component must be separately appealed. The Medicare Contractor does not believe the appeals meet the requirements of 42 C.F.R. § 405.1837 and Board Rule 8.1.

The Providers responded by explaining that the appeals involve the FTE resident count used to calculate the Providers' DGME payments. The Providers are asserting that the MAC improperly intertwined the application of the resident full-time cap and weighting factors. This is a single issue that impacts several components of each Provider's FY DGME calculation: the current year, prior year and penultimate year resident counts.

Providers explain that the establishment of the proper FTE count for DGME purposes involves a number of factors including: (1) an FTE cap established in 1996, (2) the weighting of resident FTEs when the residents are beyond their initial residency period, and (3) the hospital's resident FTE counts in its current year, prior year and penultimate year, all of which are subject to the cap and weighting in those years. The Providers argue that the statute[20] requires the MAC to determine the cap before the application of the weighting factors. However, the Providers believe that the regulation improperly applies a cap that includes a weighting factor which is then applied against a weighted FTE count for a given year[21] and which is contrary to the statute. This allegedly improper calculation methodology is applied to the Providers' current year, prior year

[18] The two cases in which the concern regarding whether the appeals contained multiple issues arose were case numbers 18-1838GC and 19-0398GC.
[19] The Board Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.
[20] 42 U.S.C. § 1395ww(h)(4)(C) and (F).
[21] 42 C.F.R. § 413.79(c)(2).

and penultimate FTE counts used to determine the Providers' DGME payments for the appealed fiscal years. Thus, the Providers argue that the Providers have appealed a single issue.

Decision of the Board

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

A. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[22] 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.[23]

On August 21, 2008, new regulations governing the Board were effective.[24] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[25] 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 D.C. 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.[26]

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[22] 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.).
[23] *Bethesda*, 108 S. Ct. at 1258-59.
[24] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[25] 201 F. Supp. 3d 131 (D.D.C. 2016).
[26] *Id.* at 142.

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

B. Background on Appeals of Precedent Facts/MAC's Assertion of the Appeal of Multiple Issues in the Group Appeals

1. The 2013 Kaiser Case and CMS' Subsequent Revisions to 42 C.F.R. § 405.1885

In 2013, the D.C. Circuit issued its decision in *Kaiser Found. Hosp. v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[27] The *Kaiser* case also involved the statutory cap on IME FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates and adjustment to the closed year's reimbursement.[28]

CMS disagreed with the *Kaiser* decision, and, in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

> …we are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it

[27] 708 F.3d 226, 232-233 (D.C. Cir. 2013).
[28] *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 229 (D.C. Cir. 2013).

> does not apply to factual findings when made as part a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation, or other legal provision permitting reauditing, revising , or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[29]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular issue in *Kaiser* . . . ."[30] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[31] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[32]

2. The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"). Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[33] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to administrative appeals."[34] The court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. However, it is clear from the *Saint Francis* case that the D.C. Circuit interpreted the reopening regulation at 42

[29] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).
[30] *Id.* at 75165.
[31] *Id.*
[32] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[33] *Id.* at 297 (citation omitted).
[34] *Saint Francis Med. Ctr. v. Azar,* 894 F.3d 290, 294 (D.C. Cir 2018) (emphasis added).

C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Moreover, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the ***interpretation*** of 42 C.F.R. § 405.1885 (as revised in 2013) because the Provider could bring suit in the D.C. Circuit.[35] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be re-determined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal*.

C. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulation (as described more fully below) and that the appeals of fiscal years involving predicate facts are governed by the D.C. Circuit's decisions in *Kaiser* and *Saint Francis.* 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. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

D. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) improperly penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between IRP residents (*i.e.*, residents in their initial training period) and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this equation results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for residents

[35] 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).

[36] *See* 42 C.F.R. § 405.1837.

(*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP resents and fellows) in nonprimary care programs:

$$\textbf{\textit{Allowable FTE count}} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times Weighted\ FTE\ Count$$ [37]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[38] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[39] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period

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[37] *See e.g.* Providers' EJR Request in case number 19-0398GC at 9.
[38] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[39] 66 Fed. Reg. at 39894 (emphasis added).

> ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[40]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[41] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[42] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[43] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ \ then\ \ c = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[44]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

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[40] (Emphasis added.)

[41] *See* 62 Fed. Reg. at 46005 (emphasis added).

[42] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

[43] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[44] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following equation:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{FY's\ Unweighted\ FTE\ Count} \times FY's\ Weighted\ FTE\ Count$$

This equation is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Further, the Board also agrees with the Provider's position that the validity of this regulation is a single issue that simply impacts several components of each Provider's FY DGME calculation: the current year, prior year and penultimate year resident counts. Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

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 appeals are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), 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. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) 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 the cases.

Board Members Participating:

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

FOR THE BOARD:

1/8/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS
Pam VanArsdale, NGS
Bruce Snyder, Novitas
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***EJR Denial for Case No 20-0154 & Request for Information in Related CIRP Groups***
University Medical Center New Orleans (Prov. No. 19-0005; FYE 6/30/2011)

Dear Ms. Goron:

As you know, you are the representative for University Medical Center New Orleans ("Provider") for the above-captioned case that involves the fiscal year ending June 30, 2011 ("FY 2011"). The Provider Reimbursement Review Board ("Board") has reviewed both your October 24, 2019 request for expedited judicial review ("EJR") in the above-captioned case and your December 16, 2019 response to the Board's November 18, 2019 request for additional information ("RFI") relating to this EJR request. As set forth more fully below, *the Board is denying the EJR request* ***and****, due to both your mismanagement of this case (as well as two related CIRP groups) and your failure to provide complete and accurate information to the Board in response to the RFI, the Board will dismiss this case if,* ***within ten (10) days,*** *you do not properly transfer this case to the related CIRP groups and confirm whether these CIRP groups are complete*.

Issue in Dispute:

On January 29, 2019, you filed this appeal on behalf of the Provider with the sole issue involving how Part C days should be counted in the DSH Calculation (SSI fraction versus Medicaid fraction). Specifically, the sole issue 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.[1]

You divided this issue into two parts, the Medicare or SSI fraction and the Medicaid fraction, and, collectively, it will be referred to as the "Part C Days issue" in the discussion below. The Part C Days issue challenges the validity of 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (the 2004 Rule) as promulgated in August 11, 2004 Federal Register.[2]

[1] Providers' EJR request at 1.
[2] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

Board Decision:

The regulation, 42 C.F.R. § 405.1837(b)(1)(i) mandates usage of group appeals (a/k/a CIRP group appeals) in certain situations involving "providers under common ownership or control":

> Two or more providers under common ownership or control that wish to *appeal to the Board a specific matter at issue that involves* a question of fact or *interpretation of* law, *regulations*, or CMS Rulings *that is common to the providers*, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, ***must*** *bring the appeal as a group appeal*.[3]

As the issue under appeal is a challenge to the validity of a regulation, it clearly falls within the mandates of § 405.1837(b)(1)(i). Further, the record is clear that the Provider is part of a health system containing at least one other provider "under common ownership or control." In this regard, the Board notes that the letter of representation for the Provider in this case includes a list of five (5) additional hospitals that were identified as part of the LSU Health Care Services Division Hospitals ("LSU chain"). Accordingly, the Board finds that the mandates of § 405.1837(b)(1)(i) are applicable to the Provider for the Part C Days issue and, as such, the Provider had the obligation, both under the regulation and Board Rules, to determine whether there were any other LSU chain providers that had the same issue for the same year (whether already appealed to the Board or would be appealed). Indeed, as detailed below, you have recognized that there are other LSU chain providers and, in fact, there are at least seven (7) other LSU chain providers with the same Part C Days issue for the same year (*i.e.*, 2011).[4]

On October 17, 2019, you filed the Provider's appeal of the 2011 NPR with the Part C Days issue and, seven days later on October 24, 2019, you requested EJR of the Provider's Part C Days issue. On November 18, 2019, the Board sent you, as the Provider's representative, an RFI asking you to determine whether a CIRP group appeal was required for the Part C Days issue for the LSU facilities given the nature of the appeal and that there were other existing LSU CIRP groups for 2011 but none identified by the Board for the Part C Days issue. To this end, the Board required you to respond within 30 days and take the following actions as relevant:

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[3] This regulation implements the requirement in 42 U.S.C. § 1395oo(f) that: "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers." *See also infra* note 6 (discussing Board Rules 12.3.1 and 19.2 for Common Issue Related Party ("CIRP") groups).

[4] For each CIRP group, you included Earl K. Long Medical Center in the original group appeal request and then you later ***directly added*** the following six (6) providers: W.O. Moss Regional Medical Center; E.A. Conway Medical Center; LSU Health Sciences Center – Shreveport; Washington St. Tammany Regional Medical Center; Leonard J. Chabert Medical Center; and University Medical Center.

> *For fiscal year 2011*, [you] **must** notify the Board if there are other members of the LSU chain which the Part C Days issue (which is the subject of the Own Motion EJR) and if so, whether collectively they would meet the $50,000 threshold. If there are other providers in the chain with the common issue *for the fiscal year*, a CIRP group **must** be established as required by regulation and the appropriate issues transferred to the CIRP group appeal. If a CIRP group is established, you must indicate whether the CIRP group is fully formed or whether there are any other related Providers pursuing the issue that have not yet received a final determination. If the Provider believes there are no other chain providers with this common issue *for the fiscal year*, they must make that attestation.[5]

On December 16, 2019, you responded to the Board's RFI stating that "there are no other members of the LSU chain" and that "[the Provider] was *inadvertently* left out of prior Part C group appeals for FYE 2011, that are no longer pending before the Board." In sum, you represented in your response that: (1) there are other LSU chain providers that have the Part C Days issue for 2011; (2) an LSU chain CIRP group had already been established for the Part C Days issue but that it was "no longer pending before the Board"; and (3) the Provider was not part of that otherwise closed CIRP group. *The Board could have stopped here and dismissed the above captioned case* because, ***based on your representations***, the Provider was not participating in the LSU chain CIRP group that was allegedly "no longer pending" and because participation in a CIRP group is mandatory for issues such as the Part C Days issue that are common to the LSU chain providers for a year (here FY 2011) pursuant to 42 C.F.R. § 405.1837(b)(1)(i) and 42 U.S.C. § 1395oo(f).

However, ***as explained below, you provided incomplete, inaccurate, and misleading information in your response to the Board's RFI***. First, you failed to provide the Board with the case number of the Part C Days CIRP group that you described as "no longer pending before the Board." Second, you inaccurately described that CIRP group as "no longer pending before the Board" and nearly misled the Board to dismiss this case.[6] Though not required, the Board as a courtesy searched its computerized docket for the CIRP group you described but for which you failed to give a case number. As a result of this review, the Board confirmed that there are in fact two (2) LSU CIRP groups for the Part C Days issue ***for 2011*** (one for the SSI fraction and one for the Medicaid fraction) and that, contrary to your representation, these appeals are currently pending

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[5] (Italics emphasis in original and bold emphasis added.)

[6] Again, if the Board had relied on ***your*** representation that the LSU chain CIRP group for 2011 Part C days were "no longer pending before the Board" (whether due to dismissal, withdrawal, or decision granting EJR), the Board would have dismissed Case No. 20-0154 because the Provider's sole issue in Case No. 20-0154 was Part C Days and the Provider failed to transfer that issue and join Case Nos. 14-2994GC and 14-2995GC even though 42 C.F.R. § 405.1837(b)(1)(i) and 42 U.S.C. § 1395oo(f) required the Provider to join it in order to pursue the Part C Days issue for 2011. *See also* Board Rule 12.3.1 (stating "Providers under common ownership or control that wish to appeal a specific matter that is common to the providers must bring the appeal as a group appeal."); Board Rule 19.2 (stating "Mandatory CIRP group appeals *must contain* ***all*** providers eligible to join the group which intend to appeal the disputed common issue." (Emphasis added)).

before the Board. Specifically, the two (2) LSU CIRP groups are: Case No. 14-2994GC (HRS LSU 2011 SSI Fraction Managed Care Part C Days CIRP Group); and Case No. 14-2995GC (HRS LSU 2011 Medicaid Fraction Medicare Managed Care Part C Days CIRP Group).

The Board's review of the electronic docket for Case Nos. 14-2994GC and 14-2995GC shows that you are the designated Provider representative for those CIRP groups and, as explained below, ***you have mismanaged these CIRP groups and failed to take prompt and appropriate actions*** *in these cases even when prompted by the Board's RFI.* First, well over a year ago, on March 19, 2018, you filed an ***improper EJR request*** for these CIRP groups as demonstrated by the fact that you represented in the Schedules of Providers ("SOPs") attached to that EJR request that these CIRP groups were not fully formed. In fact, the SOPs listed the above-captioned provider (the University Medical Center New Orleans for FY 2011) as not yet having received its final determination as of March 19, 2018. The next day, on March 20, 2018, the Board promptly denied the EJR request because the CIRP groups were not complete since the Provider had not received its final determination. *Accordingly,* ***it is abundantly clear that you should have been aware of the following facts***:

1. On March 21, 2014, you established the CIRP groups under Case Nos. 14-2994GC and 14-2995GC on behalf of the LSU chain for the Part C issue for 2011;
2. On March 9, 2018, you filed an EJR request for Case Nos. 14-2994GC and 14-2995GC and, in the SOPs attached to the EJR request, stated that the above-captioned Provider had not received its 2011 NPR and, thus, had not yet joined the CIRP groups;
3. On March 20, 2018, the Board notified you that your EJR request for the CIRP groups could not be granted because the CIRP groups were not complete (*i.e*., fully formed) as evidenced by your representation in the SOPs that the above-captioned Provider had not received its 2011 NPR and had not yet joined the CIRP groups;
4. Case Nos. 14-2994GC and 14-2995GC are still currently pending before the Board;
5. Roughly a month later, on April 22, 2019, the 2011 NPR was issued for the above-captioned Provider for whom the CIRP groups were being held open;
6. On October 17, 2019, you filed the Provider's appeal of the 2011 NPR with the Part C Days issue; and
7. 42 C.F.R. § 405.1837(b)(1)(i) required the Provider's appeal of the Part C Days issue for 2011 to be transferred to Case Nos. 14-2994GC and 14-2995GC.[7]

These facts demonstrate that, ***if you had maintained an accurate inventory of your appeals and/or properly reviewed your records in response to the Board's RFI****, you would have known to either directly add*[8] *or transfer the Provider to the CIRP group, Case No. 14-2994GC, and known that immediately requesting EJR in the above captioned* ***individual*** *case*[9] *was improper*.

[7] *See also* 42 U.S.C. § 1395oo(f); *supra* note 6 (discussing Board Rules 12.3.1 and 19.2).
[8] The Board notes that you had already ***directly added*** at least six (6) providers to Case Nos. 14-2994GC and 14-2995GC for the Part C Days issue. *See supra* note 4.
[9] You filed the Provider's individual appeal on October 17, 2019 and then, only seven (7) days later on October 24, 2019, you filed an ***improper*** EJR request for that individual appeal.

Accordingly, the Board is very displeased with your mismanagement *of Case Nos. 20-0154, 14-2994GC, and 14-2995GC,* ***and your causing the Board to needlessly waste resources*** *processing improper or inaccurate filings. The Board reminds you that, as a provider's representative, it is* ***your*** *responsibility, among other things, to: (a) maintain an accurate inventory of your clients' appeals and any related filings and Board correspondence; (b) confirm whether your client is subject to the CIRP group requirements in 42 C.F.R. § 405.1837(b)(1)(i); and (c) if so, ensure that your client complies with those requirements (e.g., joining the relevant existing open CIRP group or establishing a new CIRP group if one had not been previously established). Finally, you should always ensure that you respond accurately and completely to any Board inquiries.* ***Pursuant to 42 C.F.R. § 405.1868(b), the Board may consider other remedial actions if you continue to make improper or inaccurate filings, including but not limited to, sending direct notice to the impacted underlying provider(s).***

Conclusion:

The LSU chain CIRP groups for the Part C Days issue for 2011 are currently pending before the Board under Case Nos. 14-2994GC and 14-2995GC and have remained open because they have been awaiting the addition of the above-captioned Provider (*i.e.*, University Medical Center New Orleans). In this regard, 42 C.F.R. § 405.1837(b)(1)(i) mandates that you transfer the Provider from the above-captioned individual appeal to these CIRP groups and confirm whether these CIRP groups are complete. Accordingly, the Board denies the Provider's request for EJR in the above-captioned appeal because it must be filed as part of these CIRP groups. *The Board requires that,* ***within ten (10) days of the date this letter is signed*** *(i.e., by Tuesday, January 21, 2020), you complete the transfer of the Provider to Case Nos. 14-2994GC and 14-2995GC* ***and*** *confirm whether the CIRP groups under Case No. 14-2994GC and 14-2995GC are complete*. Pursuant to 42 C.F.R. § 405.1868(b), *failure to comply with this deadline for the transfer request will result in the Board dismissing Case No. 20-0154 and, similarly, failure to confirm by this deadline whether Case Nos. 14-2994GC and 14-2995GC are complete will result in the Board deeming them complete based on the transfers/direct adds that were completed prior to the deadline.*

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

1/10/2020

X Clayton J. Nix

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

cc: Justine Lattimore, Novitas Solutions
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Leslie Demaree Goldsmith, Esq.
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RE: ***EJR Determination-Baker Donelson DGME Appeals***
Ohio State Univ. Hosps CY 2016 DGME Penalty to FTE Count Group
Case No. 19-0746GC

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' 17, 2019 request for expedited judicial review ("EJR") (received December 18, 2019). The decision of the Board is set forth below.

The Providers in this case are challenging:

> [T]he validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(d). The regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of weighting factors. 42 U.S.C. § 1395ww(h)(4)(F). The effect of the . . . regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period ("IRP"), and it prevents Providers from claiming their full unweighted FTE caps authorized by statute. . . .[1]

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

[1] Providers' EJR requests at 1.
[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

A hospital's "resident FTE count" for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

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[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).
[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .

[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish *new* programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap,* the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
>
> plus
>
> (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's *reduced cap*.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15] This information is used to determine whether the hospital exceeds its unweighted FTE cap.

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. § § 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Providers' Position

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)((iii), is contrary to the statute at 42 U.S.C. § 1395ww(h) for several reasons. First, the regulation creates a weight FTE cap. The Providers believe that the statute plainly requires the Secretary to determine the cap "before the application of weighting factors," which is an unweighted cap.[17] The Secretary instead determines a weighted FTE cap for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE (UCap/UFTE) = WCAP, is applied to the weighted FTE count in the current year, which creates a second FTE cap that is an absolute limit on the number of FTEs that can go into the DGME payment calculation. This second cap is determined after the application of the weighting factors to fellows in the current year, which the Providers allege violates Congress' directive to determine the cap before the application of the weighting factors.

Second, the Secretary's weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The downward impact on the FTE count increases as a hospital trains more residents beyond the IRP.

Third, the Providers assert, the regulation imposes a weighting factor that reduces the FTE time by more the 0.5 contrary to the statute. In these cases, all of the Providers are over their FTE caps and train residents that are beyond the IRP and are prevented from reaching their full FTE caps due to the Secretary's regulation. The Providers suffered a downward payment adjustment that is greater than may be imposed by the statutory 0.5 weighting factor. By establishing the cap based on the hospital's unweighted FTE count for 1996, Congress entitled the Providers to claim FTEs up to that cap. The Providers contend that the regulation renders this impossible for these Providers simply because they trained residents who are beyond the IRP. The Providers assert that the regulation, 42 C.F.R. § 412.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and is, therefore, invalid.

Parties Comments Regarding Whether the Groups Contain a Single Issue

In this case, the Medicare Contractor, CGS Administrators, posited that the current, prior and penultimate weighted DGME counts are different components of the DGME calculation. The

[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).

Medicare Contract points out that pursuant to Board Rule 8.1[18] each contested component must be separately appealed. The Medicare Contractor does not believe the appeals meet the requirements of 42 C.F.R. § 405.1837 and Board Rule 8.1.

The Providers responded by explaining that the appeals involve the FTE resident count used to calculate the Providers' DGME payments. The Providers are asserting that the MAC improperly intertwined the application of the resident full-time cap and weighting factors. This is a single issue that impacts several components of each Provider's FY DGME calculation: the current year, prior year and penultimate year resident counts.

Providers explain that the establishment of the proper FTE count for DGME purposes involves a number of factors including: (1) an FTE cap established in 1996, (2) the weighting of resident FTEs when the residents are beyond their initial residency period, and (3) the hospital's resident FTE counts in its current year, prior year and penultimate year, all of which are subject to the cap and weighting in those years. The Providers argue that the statute[19] requires the MAC to determine the cap before the application of the weighting factors. However, the Providers believe that the regulation improperly applies a cap that includes a weighting factor which is then applied against a weighted FTE count for a given year[20] and which is contrary to the statute. This allegedly improper calculation methodology is applied to the Providers' current year, prior year and penultimate FTE counts used to determine the Providers' DGME payments for the appealed fiscal years. Thus, the Providers argue, the Providers have appealed a single issue.

Decision of the Board

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

A. Background on Appeals of Self-Disallowed Costs

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[21] In that case, the Supreme Court concluded that a cost report submitted in

[18] The Board Rules can be found on the internet at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/Downloads/PRRB-Rules-August-29-2018.pdf.
[19] 42 U.S.C. § 1395ww(h)(4)(C) and (F).
[20] 42 C.F.R. § 413.79(c)(2).
[21] 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.).

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.[22]

On August 21, 2008, new regulations governing the Board were effective.[23] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*") before the D.C. District Court.[24] 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 D.C. 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.[25]

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

B. Background on Appeals of Precedent Facts/MAC's Assertion of the Appeal of Multiple Issues in the Group Appeals

In this case, the Board concludes that the Medicare Contractor's assertion that the inclusion of prior and penultimate years in this group appeal constitutes the appeal of precedent facts, not the inclusion of multiple issues within the group appeal. Consequently, the decsion in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*")[26] is applicable, as explained in greater detail below.

1. The 2013 Kaiser Case and CMS' Subsequent Revisions to 42 C.F.R. § 405.1885

In 2013, the D.C. Circuit issued its decision in *Kaiser Found. Hosp. v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed

[22] *Bethesda*, 108 S. Ct. at 1258-59.
[23] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[24] 201 F. Supp. 3d 131 (D.D.C. 2016).
[25] *Id*. at 142.
[26] *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018).

years provided the change will only impact the total reimbursement determination in open years."[27] The *Kaiser* case also involved the statutory cap on IME FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates and adjustment to the closed year's reimbursement.[28]

CMS disagreed with the *Kaiser* decision, and, in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

> …we are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation, or other legal provision permitting reauditing, revising , or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[29]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular

[27] 708 F.3d 226, 232-233 (D.C. Cir. 2013).
[28] *Kaiser Found. Hosps. v. Sebelius*, 708 F.3d 226, 229 (D.C. Cir. 2013).
[29] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).

issue in *Kaiser* . . . ."[30] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[31] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[32]

2. The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"). Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[33] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to administrative appeals."[34] The court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. However, it is clear from the *Saint Francis* case that the D.C. Circuit interpreted the reopening regulation at 42 C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Moreover, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the interpretation of 42 C.F.R. § 405.1885 (as revised in 2013) because the Provider could bring suit in the D.C. Circuit.[35] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be re-determined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal*.

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[30] *Id.* at 75165.
[31] *Id.*
[32] 78 Fed. Reg. 74826 (Dec. 10, 2013).
[33] *Id.* at 297 (citation omitted).
[34] *Saint Francis Med. Ctr.* at 294 (emphasis added).
[35] 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).

C. Board Jurisdiction

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R since they are challenging a regulation (as described more fully below) and that the appeals of fiscal years involving predicate facts are governed by the D.C. Circuit's decisions in *Kaiser* and *Saint Francis*. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[36] and the appeals were timely filed.[37] Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal and underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

D. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between IRP residents (*i.e.*, residents in their initial training period) and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this equation results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in their request for EJR used to calculate the allowable count for residents (*i.e.*, IRP residents and fellows) in primary care and obstetrics and gynecology programs and separately for residents (*i.e.*, IRP resents and fellows) in nonprimary care programs:

$$\textbf{\textit{Allowable FTE count}} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times Weighted\ FTE\ Count$$ [38]

Accordingly, the Board set out to confirm the Providers' assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[39] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only***

[36] *See* 42 C.F.R. § 405.1837(a)(3).
[37] *See* 42 C.F.R. § 405.1835(a)(d).
[38] *See* Provider's EJR Request at 4.
[39] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[40] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[41]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[42] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[43] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[44] (*i.e.*, ratios) using variables a, b, c, and d:

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[40] 66 Fed. Reg. at 39894 (emphasis added).
[41] (Emphasis added.)
[42] *See* 62 Fed. Reg. at 46005 (emphasis added).
[43] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[44] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

$$If\ \frac{a}{b} = \frac{c}{d}\ then\ \text{c} = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[45]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following equation:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{FY's\ Unweighted\ FTE\ Count} \times FY's\ Weighted\ FTE\ Count$$

This equation is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Providers are challenging the validity of § 413.79(c)(2)(iii). Further, the Board also agrees with the Provider's position that the validity of this regulation is a single issue that simply impacts several components of each Provider's FY DGME calculation: the current year, prior year and penultimate year resident counts. Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy the Providers are seeking. Consequently, EJR is appropriate for the issue under dispute in these cases.

[45] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

E. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the participants in this appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), 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. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) 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 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 this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

1/14/2020

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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January 14, 2020

Kenneth Marcus
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Cecile Huggins
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RE: Request for Consolidation of FFY 2020 0.7% ATRA Reduction CIRP Groups
Baptist Memorial FFY 2020 0.7% ATRA Reduction CIRP Group
PRRB Case Number: 20-0506GC

Dear Mr. Marcus and Ms. Huggins:

The Provider Reimbursement Review Board (the "Board") is in receipt of the Representative's December 20, 2019 request to consolidate the Trinity Health FFY 2020 0.7% ATRA Reduction CIRP Group (Case No. 20-0506GC) and the Baptist Memorial 0.7% ATRA Reduction CIRP Group (Case No. 20-0535GC). According to the Representative's correspondence both groups, which are fully formed, involve the identical issue for which the Representative expects to file a request for expedited judicial review ("EJR"). However, the Board notes that, pursuant to 42 C.F.R. § 405.1837(b)(iii), [a] group appeal involving two or more providers under common ownership or control must consist entirely of providers under common (to all) ownership or control." Further, Board Rule 12.7 indicates that "[p]roviders that are not part of a CIRP group may not join a CIRP appeal." Therefore, the Board denies the requested consolidation. Notwithstanding, if a request for EJR is not filed in these cases, the appeals may be heard concurrently. The deadlines established in the Board's Acknowledgement and Critical Due Dates letters issued on December 27, 2019 and December 31, 2019, respectively, remain in effect. If the Representative does decide to file a request for EJR, it may file a single request that references both cases.

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:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Joe Willey, Esq.
Katten, Muchin, Rosenman, LLP
575 Madison Avenue
New York, NY 10022-2585

RE: **Jurisdictional Determination**
NYCHHC FFY 2019 Understatement of D & C Repayment Adjustment Group
Case No. 19-1791GC

Dear Mr. Willey:

The Provider Reimbursement Review Board ("Board") has reviewed the original hearing request in the above referenced group appeal and its jurisdictional determination is set forth below.

Background

The Providers' appeal was received[1] in the Board's offices on February 14, 2019, 181 days after the publication of the August 17, 2018 Federal Register.[2] The Providers in this case are appealing Federal standardized amount(s) ("Standardized Amount") established under the Medicare Inpatient Prospective Payment System ("IPPS") for Federal fiscal year ("FFY") 2019 as improper. In the Federal year ("FY") 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believed that, by increasing the number of MS–DRGs and more fully

[1] The date of receipt is presumed to be the date of delivery. 42 C.F.R. § 405.1801(a)(2)(i) (2008). A provider has the right to a Board hearing if the date of receipt of the provider's hearing request is not later than 180 days after the date of receipt of the intermediary's/Medicare Administrative Contractor's (MAC's) or Secretary's determination. 42 C.F.R. § 405.1835(a)(3)(ii)(2008). *But see* 42 U.S.C. § 1395oo(a)(3) which requires an appeal be filed "within 180 days of the Secretary's notice." The publication of the Inpatient Prospective Payment System Rules in the Federal Register constitutes the Secretary's notice of the rates for the upcoming Federal fiscal year.

[2] *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986) ("[A] year end cost report is *not* a report which is necessary in order for the Secretary to make PPS payments, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal") and *Dist. of Columbia Hosp. Ass'n Wage Index Group Appeal*, HCFA Adm'r Dec., Medicare & Medicaid Guide (CCH) ¶ 41,025 (Jan. 15, 1993) (publication of the wage index in the Federal Register is a final determination which can be appealed to the Board).

[3] 72 Fed. Reg. 47130, 47140 through 47189 (Aug. 22, 2007)

[4] of the Department of Health and Human Services.

taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs will encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. These adjustments, both positive and negative, continued through Federal fiscal year 2019.

Decision of the Board

The Board finds that the appeal was not timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which requires an appeal be filed "*within 180 days after notice of the . . .Secretary's final determination.*"[6] This appeal was received in the Board's offices 181 days after the issuance of the August 17, 2018 Federal Register giving notice of the inpatient prospective payment rates, including the Standardize Amounts which had been adjusted to reflect changes in documentation and coding of diagnoses, for Federal fiscal year (FFY) 2019. Consequently, the Board dismisses the appeal.

The Federal Register notice is the Secretary's final notice of the IPPS rates for each Federal fiscal year. The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[7] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[8] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, sections 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[9] of the Social Security Act [relating to disclosure of information] as it applies to [CMS]. . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[10] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, *requires publication to serve as*

[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] (emphasis added).
[7] *See* 42 C.F.R. § 405.1867.
[8] of the Department of Health and Human Services.
[9] 42 U.S.C. § 1306(a).
[10] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act (FOIA).

notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

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

In order to comply with the statutes and regulations requiring that public notice be given, CMS publishes the schedules of the Prospective Payment System (PPS) rates in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). This regulation was created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[11]

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

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[12]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office (GPO) promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet on the GPO website.[13] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[14] Consequently, ***the Provider is deemed to have notice of the standardized amount on the date the Federal Register was published and made available online***.[15]

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[11] *See also* 42 C.F.R. Part 401, Subpart B.

[12] (Emphasis added.)

[13] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).

[14] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.

[15] While there is the official publication date (*e.g.*, the official publication date of the FY 2019 IPPS final rule is August 17, 2018), it is the Board's understanding that the GPO (or the sponsoring agency) may post a copy of a rulemaking several days in advance of the official publication date. The Board considers the official publication date as the official notice to the public and, as such, 180-day clock starts from the official publication date regardless of whether it may have been posted in advance.

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

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[16]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: the date of publication of the Federal Register is the date the Providers are deemed to have notice of the IPPS rules including the Standardized Amount. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office. Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents. This is reflected in Board Rule 4.3.2 which states:

> The date of receipt of a Federal Register Notice is *the date the Federal Register is published*. The appeal period begins on the date of publication and ends 180 days from that date.

As a result, the Providers did not file the hearing request within 180 days of the publication of the Federal Register notice and the Board concludes the appeal was not timely. The appeal is dismissed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

1/15/2020

X Clayton J. Nix

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

cc: Pam VanArsdale, NGS
Wilson Leong, FSS

[16] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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J.C. Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Suite 570A
Arcadia, CA 91006

RE: ***Jurisdictional Decision***
St. Luke's East Hospital Lee's Summit (26-0216)
FYE: 12/31/2009
PRRB Case: 13-2963

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 14-0948GC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On August 23, 2013, the Board received Provider's Individual Appeal Request appealing their February 25, 2013 Notice of Program Reimbursement ("NPR") from the Medicare Contractor. The initial appeal contained six (6) issues, three (3) of which have been transferred to group appeals. One of the issues transferred to a CIRP group appeal (PRRB Case Number 14-0948GC) was "DSH/SSI - Systemic Errors."[1] The other three (3) remaining issues are the DSH/SSI Provider Specific issue, Medicaid Eligible Days, and Medicaid Eligible Observation Bed Days.

Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

[1] Model Form D – Request to Transfer Issue to a Group Appeal (Apr. 9, 2014).
[2] Individual Appeal Request, Tab 3, Issue 1 (Aug. 23, 2013).

Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records;
2. Paid days vs. eligible days;
3. Not in agreement with provider's records;
4. Fundamental problems in the SSI percentage calculation;
5. Covered v. total days;
6. Non-Covered Days;
7. CMS Ruling 1498-R;
8. Matching Methodology Pursuant to CMS Ruling 1498-R
9. Failure to adhere to required notice and comment rulemaking procedures.[3]

On April 22, 2014, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because the MAC did not render a final determination over it. They argue that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination.[4]

Provider filed a response on May 5, 2014, in which they argue that they are "not only addressing a realignment of the SI percentage, but also addressing various errors of omission and commission that do not fit into the 'systemic errors' category."[5]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board should note that such request is a provider election that must be submitted in writing to the MAC and is not an appealable issue before the Board. Indeed, without the Medicare Contractor rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

[3] *Id.* at Issue 2.
[4] Medicare Administrative Contractor's Jurisdictional Challenge (Apr. 22, 2014).
[5] Jurisdictional Response at 1 (May 5, 2014).

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:

1/17/2020

X Gregory H. Ziegler

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

RE: ***Jurisdictional Decision***
Bethesda Memorial Hospital (10-0002)
FYE: 9/30/2008
PRRB Case: 14-0980

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case No. 13-2964G. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On November 25, 2013, the Board received Provider's Individual Appeal Request appealing their May 28, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2008 from the Medicare Contractor. The initial appeal contained eleven (11) issues, seven (7) of which have been transferred to group appeals. One of the issues transferred to a group appeal (PRRB Case Number 13-2694G) was "DSH/SSI - Systemic Errors."[1] The other four (4) remaining issues are the DSH/SSI Provider Specific issue, Medicaid Eligible Days, Medicaid Eligible Observation Bed Days, and Medicare Crossover Bad Debts.

Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[2]

[1] Model Form D – Request to Transfer Issue to a Group Appeal (Aug. 14, 2014).
[2] Individual Appeal Request, Tab 3, Issue 1 (Nov. 25, 2013).

Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as "[w]hether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage." More specifically, Provider lists the following reasons for challenging its SSI percentage:

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

On January 13, 2020, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over the DSH/SSI Provider Specific issue because it is the same as the DSH/SSI - Systemic Errors issue that was transferred to PRRB Case Number 13-2694G. They argue that the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination, and also that the Provider abandoned this portion of their appeal by failing to brief it in their position paper.[4]

Board Decision

Based upon review of the two DSH/SSI issue statements, Provider is challenging the same underlying SSI data in both of the issues and they do not appear to be different in any significant way. Pursuant to Board Rule 4.6, a provider may not appeal an issue from a final determination in more than one appeal. Therefore, the Board finds that Provider's two DSH/SSI issues are the same and, because Provider transferred its DSH/SSI - Systemic Errors issue to a group appeal, dismisses their DSH/SSI Provider Specific issue from the instant appeal.

In addition, with respect to Provider's statement that it "hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period[,]" the Board notes that such request is a provider election that must be submitted in writing to the Medicare Contractor and is not an appealable issue before the Board. Indeed, without the Medicare Contractor rendering a determination of the realignment issue, the Provider would not have exhausted its available remedy of requesting CMS to recalculate the SSI ratio using the Provider's fiscal year under 42 C.F.R. § 412.106(b)(3).

[3] *Id.* at Issue 2.
[4] Medicare Administrative Contractor's Jurisdictional Challenge (Jan. 13, 2020). The Jurisdictional Challenge also argues that there were no adjustments related to the Medicaid Eligible Observation Bed Days and Medicare Crossover Bad Debts issues. These aspects of the Jurisdictional Challenge will be addressed under separate cover.

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

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:

1/21/2020

X Gregory H. Ziegler

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

cc:

Wilson C. Leong, Esq., Federal Specialized Services
Geoffrey Pike, First Coast Service Options, Inc.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
1508 Woodlawn Drive, Suite 100
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Electronic Delivery

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

Byron Lamprecht
WPS Government Health Administrators
2525 N. 117th Avenue, Suite 200
Omaha, NE 68164

RE: *Jurisdictional Decision*
Stringfellow Memorial Hospital
Provider No.: 01-0038
FYE: 06/30/2016
PRRB Case No.: 18-1862

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board (PRRB or Board) has reviewed the documents in the above-referenced appeal. The Board finds that it does not have jurisdiction over the Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific) issue. Further, the Board finds that it need not address the jurisdictional challenges related to the Disproportionate Share Hospital (DSH) UCC Distribution Pool issue or the Two Midnight Census IPPS Payment Reduction issue, as these issues have been transferred to group appeals.

Background

On September 21, 2018, Stringfellow Memorial Hospital (Stringfellow) filed an appeal from an original Notice of Program Reimbursement (NPR) dated April 02, 2018 for the fiscal year ending (FYE) June 30, 2016. Stringfellow appealed the following nine issues:

1) DSH SSI Percentage (Provider Specific) including SSI realignment,
2) DSH SSI Percentage,
3) DSH SSI Percentage Managed Care Part C Days,
4) DSH SSI Percentage Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days),
5) DSH Medicaid Eligible Days,
6) DSH Medicaid Fraction Managed Care Part C Days,
7) DSH Medicaid Fraction Dual Eligible Days (Exhausted Part A Benefit Days, MSP Days and No-Part A Days),
8) DSH UCC Distribution Pool and

9) Two Midnight Census IPPS Payment Reduction.[1]

On January 29, 2019, the Medicare Contractor filed a Jurisdictional Challenge challenging jurisdiction over the DSH SSI Percentage (Provider Specific) issue (Issue 1), the SSI realignment issue (issue 1), the DSH UCC Distribution Pool issue (Issue 8), and the Two Midnight Census IPPS Payment Reduction issue (Issue 9). On February 25, 2019, Stringfellow filed a Jurisdictional Response.

Medicare Contractor's Position

DSH SSI Percentage (Provider Specific)

The Medicare Contractor contends that issue 1, the DSH SSI Percentage (Provider Specific) issue, has three components: SSI data accuracy, individuals who are eligible for SSI but did not receive SSI payment and SSI realignment. The Medicare Contractor maintains the portion of issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment should be dismissed because they are duplicative of issue 2, the DSH SSI Percentage issue, which was transferred to case number 19-0173GC. The Medicare Contractor notes in issue 1 Stringfellow asserts that "its'(sic) SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation." In issue 2 Stringfellow asserts "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report were incorrectly computed." The Medicare Contractor argues in both issues 1 and 2 Stringfellow is disputing whether the correct SSI percentage was used in computing its DSH payments. The Medicare Contractor requests that the Board dismiss the portions of issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment as they are duplicates of Stringfellow's appeal in issue 2.[2]

The Medicare Contractor asserts the portion of issue 1 related to SSI realignment should also be dismissed because there was no final determination over the SSI realignment issue; also, the appeal is premature as Stringfellow has not exhausted all available remedies. The Medicare Contractor contends the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. To date, Stringfellow has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Medicare Contractor requests that the Board dismiss the portion of issue 1 concerning SSI realignment from the appeal as well.[3]

[1] The Provider withdrew the Medicaid Eligible Days issue from this appeal on April 5, 2019. On April 17, 2019, the Provider requested to transfer Issues 2, 3, 4, 6, 7, 8, and 9 to group appeals. The only issue that remains pending in this individual appeal is Issue 1 – DSH SSI Percentage (Provider Specific).
[2] Medicare Administrative Contractor's January 29, 2019 Jurisdictional Challenge at 2-3.
[3] *Id.*

DSH UCC Distribution Pool

The Medicare Contractor maintains issue 8, the DSH UCC Distribution Pool issue, should also be dismissed because it is not an appealable issue; further, issue 8 is a duplicate of Stringfellow's appeal in case numbers 15-1134GC, Community HS FFY 2015 Uncompensated Care Pool CIRP Group, and 16-0769GC, Community Health Systems FFY 2016 Uncompensated Care Pool Calculation CIRP. The Medicare Contractor argues the Board does not have jurisdiction over the DSH UCC payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2). The Medicare Contractor notes in *Fla. Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Serv.*, 830 F.3d 515 (D.C. Cir. 2016), the Court concluded that preclusion was absolute. The Medicare contractor contends the Board has previously found that it lacks jurisdiction over the DSH UCC Distribution Pool issue because judicial and administrative review of the calculation is barred by statute and regulation.[4]

The Medicare Contractor notes that Stringfellow was a participant in case numbers. 15-1134GC and 16-0769GC which covered the same DSH UCC payment issue; jurisdiction for both cases was successfully challenged and the Board dismissed the cases on July 30, 2018. The Medicare Contractor asserts the appeal in case number 15-1134GC was taken from the Federal Register dated August 22, 2014; the appeal in case number 16-0769GC was taken from the Federal Register dated August 17, 2015. The Medicare Contractor maintains together these appeals encompass the service dates covered in the April 2, 2018 NPR at issue in this appeal. The Medicare Contractor argues as the DSH UCC payment issue was pursued in case numbers 15-1134GC and 16-0769GC, the Board should dismiss the DSH UCC payment issue from this case per PRRB Rule 4.6.2 which requires appeals of the same issue from distinct determinations to be pursued in a single appeal.[5]

Two Midnight Rule

The Medicare Contractor contends that subject matter jurisdiction is lacking over issue 9, the Two Midnight Census IPPS Payment Reduction issue, because CMS has already developed and implemented relief for this issue. Further, that issue 9 is a duplicate of Stringfellow's appeal in case number 15-1175GC, CHS FFY 2015 Two Midnights 0.2% IPPS Payment Reduction CIRP Group, for the dates of July 1, 2015 through September 30, 2015 and case number 16-0785GC, CHS FFY 2016 Two Midnights 0.2% IPPS Payment Reduction CIRP Group, for the dates of October 1, 2015 through June 30, 2016.[6] The Medicare Contractor argues that CMS through its rule making authority consistent with the *Shands Jacksonville Medical Center Inc., et al. v. Burwell*, No. 14-263 (D.D.C. Sept. 2015) remand, has established a correction applicable to the 2014 through 2016 complaints about the 0.2% reduction attributable to the Two midnight rule. CMS determined that it was the most administratively feasible approach to implement the correction in the federal fiscal year (FFY) 2017. The Medicare Contractor contends this CMS policy decision divest the Board of authority to consider relief in a FFY 2014-2015 appeal. The Medicare Contractor argues subject matter jurisdiction is not present; the Board should dismiss

[4] *Id.* at 2, 4.
[5] *Id.* at 2, 5.
[6] *Id. at 2.*

the issue for lack of jurisdiction.

The Medicare Contractor asserts the appeal in case number 15-1175GC in which Stringfellow was a participant, for the period of July 1, 2015 through September 30, 2015, was taken from the Federal Register dated August 22, 2014; the appeal in case number 16-0785GC in which Stringfellow was a participant, for the period of October 1, 2015 through June 30, 2016, was taken from the Federal Register dated August 27, 2015. The current appeal is from an April 2, 2018 NPR. The Medicare Contractor maintains issue 9 is a duplicate of case numbers 15-1175GC and 16-0785GC for the dates listed above and should be dismissed pursuant to PRRB Rule 4.6.2 which requires appeals of the same issue from distinct determinations to be pursued in a single appeal.[7]

Provider's Position

On February 25, 2019, Stringfellow filed a Jurisdictional Response in which they contend that each of the appealed DSH SSI percentage issues are separate and distinct issues which represent different components of the SSI issue which was adjusted during audit. Stringfellow maintains issue 2 addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp.2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage. Stringfellow contends issue 1, including SSI realignment, addresses the various errors of omission and commission that do not fit into the systemic errors category. Stringfellow argues since these issues represent different components of the SSI issue, the Board should find jurisdiction over both the DSH SSI Percentage (Provider Specific) including SSI Realignment issue (issue 1) and the DSH SSI Percentage (Systemic) issue (issue 2).[8]

In regards to issue 8, the DSH UCC Distribution Pool, Stringfellow maintains that the statute does not authorize the Secretary to "estimate" the uninsured patient population percentage;[9] they are challenging not only the amount of the estimate used by the Secretary in computing factors 1-3 but also the regulations and instructions relied upon by the Secretary in computing those estimates. Specifically, they are challenging the annual IPPS rule which incorporates the defective estimates used by the Secretary. Stringfellow asserts, as such, the statutory preclusion clause contained in 42 U.S.C. § 1395ww(r)(3) does not bar administrative or judicial review.[10] In regards to issue 9, the Two Midnight Census IPPS Payment Reduction issue, Stringfellow disputes that CMS has issued a correction to the .2 percent payment reduction imposed by the FY 2014 final rule. Stringfellow disagrees that the one-time .06 positive adjustment in the FY 2017 final rule makes it whole for the injury caused by the .2 payment reduction imposed by the FY 2014 IPPS final rule for FYs 2014-2016. For these reasons, Stringfellow requests the Board find that it has jurisdiction over these issues.

[7] *Id.* at 6-7.
[8] Provider's February 25, 2019 Jurisdictional Response at 1-2.
[9] *Id.* at 3.
[10] *Id.* at 6.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

DSH SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over issue 1, the DSH SSI Percentage (Provider Specific) issue. The jurisdictional analysis for issue 1 has two relevant aspects to consider: 1) Stringfellow disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) Stringfellow 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 1—Stringfellow disagreeing with how the Medicare Contractor computed its SSI percentage that would be used to determine its DSH percentage—is duplicative of issue 2, the DSH SSI Percentage issue that was transferred to case no. 19-0173GC on April 17, 2019. The DSH SSI Percentage (Provider Specific) issue, issue 1, concerns "whether the Medicare Administrative Contractor ("MAC') used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation." The legal basis for Stringfellow's DSH SSI Percentage (Provider Specific) issue is 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)." Specifically Stringfellow 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 ." Stringfellow asserts that "its' [sic] SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation."[11]

The DSH SSI Percentage, issue 2, that was transferred to case no 19-0173GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F). Stringfellow asserts "the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the Lead MAC to settle their Cost Report was incorrectly computed." Also, "the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)." The issue concerns "[w]hether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital . . . calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)."[12] The Board finds that the DSH SSI Percentage (Provider Specific) issue, issue 1, is duplicative of the DSH SSI Percentage issue, issue 2, transferred to case no. 19-0173GC. Because the issue is duplicative, and duplicative

[11] Provider's September 21, 2018 Individual Appeal Request at Tab 3, Issue 1.
[12] *Id.* at Issue 2.

issues appealed from the same final determination[13] are prohibited by PRRB Rule 4.6.1 (August 29, 2018),[14] the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue from issue 1.

The Board also dismisses the second aspect of the DSH SSI Percentage (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 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 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. There is nothing in the record to indicate that Stringfellow has made a formal request to CMS through the Medicare Contractor and that the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Thus, the Board dismisses this aspect of the DSH SSI Percentage (Provider Specific) issue from issue 1 as well.

DSH UCC Distribution Pool

Issue 8, the DSH UCC Distribution Pool issue was transferred to case no. 19-0177GC, CHS CY 2016 HMA DSH Uncompensated Care Distribution Pool CIRP Group, on April 17, 2019. The Medicare Contractor maintains that the Board should dismiss issue 8, the DSH UCC Distribution Pool issue, from this appeal per PRRB Rule 4.6.2 because the issue has been transferred to a group appeal.

PRRB Rule 4.6.2 (August 29, 2018) provides that "[a]ppeals of the same issue from distinct determinations must be pursued in a single appeal." The Provider requested to transfer the UCC Distribution Pool issue to a group appeal, case number 19-0177GC; the Board issued a decision denying jurisdiction and closing case number 19-0177GC on November 18, 2019. Therefore, the Board finds that the it need not address the UCC Distribution Pool issue as it has already denied jurisdiction over Stringfellow as a participant in case number 19-0177GC.

Two Midnight Rule

Issue 9, the Two Midnight Census IPPS Payment Reduction issue was transferred to case no. 19-0185GC on April 17, 2019. The Medicare Contractor maintains that the Board should dismiss issue 9, the Two Midnight Rule issue, from this appeal per PRRB Rule 4.6.2 because the issue has been transferred to a group appeal.

The Provider requested to transfer the Two Midnight Rule issue to case number 19-0185GC, which is still pending before the Board. The Board finds that it need not address the jurisdictional challenge for the Two Midnight Rule issue because the issue is no longer pending in this individual appeal.

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[13] Issues 1 and 2 were appealed from an April 02, 2018 NPR.
[14] PRRB Rule 4.6.1 Single Issue from One Determination (August 29, 2018) "[a] provider may not appeal an issue form a single final determination in more than one appeal."

Conclusion

In summary, the Board concludes that it does not have jurisdiction over issue 1, the DSH SSI Percentage (Provider Specific) issue including SSI realignment. Further, the Board will not address the jurisdictional challenge for the DSH UCC Distribution Pool issue, because it was transferred to case number 19-0177GC and the Board has since denied jurisdiction over the group issue and closed the appeal. Last, the Board will not address the jurisdictional challenge for the Two Midnight Census IPPS Payment Reduction issue, because it was transferred to case number 19-0185GC, therefore the issue is no longer pending in this individual appeal.

Case number 18-1862 is hereby closed and removed from the Board's docket as no issues remain pending in the appeal.

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

1/21/2020

X Gregory H. Ziegler

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

cc: Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Mr. Brannon Wiltse
Admnistrator
Lifeway Hospice, Inc.
4040 State Hwy 121, Ste. 140
Carrollton, TX 75010

Ms. Cecile Huggins
Appeals Manager, Provider Cost Report Appeals
Palmetto GBA (J-J)
Internal Mail Code 380
P.O. Box 100307
Camden, SC 29202-3307

RE: Lifeway Hospice (Prov. No. 74-1612)
FYE 9/30/2018
Case No. 20-0517

Dear Mr. Wiltse and Ms. Huggins:

On November 25, 2019, the Provider Reimbursement Review Board ("Board") received the Provider's appeal request, to which the Board assigned Case No. 20-0517. Parties must reference the case number and provider information on all correspondence with the Board. As set forth below, the Board hereby dismisses Case No. 20-0517.

PERTINENT FACTS:

The appeal request consisted of a single page letter and a copy of the "Provider Self-Determined Aggregate Cap Limit" calculation. Within the appeal request letter, the Provider states that it is filing the appeal in response to the Notice of Program Reimbursement ("NPR") sent on November 6, 2019. However, the Provider did not submit a copy of that final determination or other issue-related support such as the Medicare contractor's final calculation of the aggregate cap.

Board Rule 3.4[1] addresses service on opposing parties and specifies that "[c]opies of *any* document filed with the Board must simultaneously be sent to the opposing party **and** to the Appeals Support Contractor."[2] However, the Board notes that neither the Medicare Contractor (Palmetto GBA) nor the Appeals Support Coordinator (Federal Specialized Services) were copied on this appeal request.

BOARD DETERMINATION:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the 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. 42 C.F.R § 405.1835(b) and Board Rule 7 address the required contents of a Board appeal request. In this regard, 42 C.F.R. § 405.1835(b) specifies, among other things, that "[t]he provider's request for a Board hearing . . . must be submitted in writing to the Board, and the request must include . . . . [a] copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider

[1] The Board Rules are available on the Board's website at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.
[2] (Italics emphasis added and bold emphasis in original.)

considers necessary to satisfy the hearing request requirements." This regulation also specifies that the Board "may dismiss" an appeal when it fails to meet this minimum filing requirement. Similarly, Board Rule 6.1.1. states, in part, "The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b)."

The Board finds that Case No. 20-0517 was not filed in accordance with the regulations stated at 42 C.F.R. § 405.1835(b) and the Board Rules 3.4 and 7.1. The Provider failed to include in its appeal request the required copy of the final determination at issue and the supporting issue documentation, specifically the Notice of Program Reimbursement and the Medicare Contractor's hospice cap calculation in dispute. Further, the Provider failed to properly serve the opposing party, namely Palmetto GBA (the MAC) and Federal Specialized Services (the Appeals Support Coordinator for the MAC). As a result, the Board hereby dismisses Case No. 20-0517 and removes it from its docket.

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

Board Members Participating:

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

Sincerely,

1/22/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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Arcadia, CA 91006

RE: ***Part C Days Medicaid and Medicare Proxy – Expedited Judicial Review Determination***
Gnaden Huetten Memorial Hospital (Prov. No. 39-0194)
FYE 06/30/2012
Case No. 15-1138

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's December 30, 2019, Request for Expedited Judicial Review ("EJR") of the above referenced appeal. The Board's jurisdictional determination and decision regarding the EJR request is set forth below.

Issue in Dispute

The relevant issue in this appeal is:

> The MAC failed to include patient days applicable to MA patients who were also eligible for Medicaid in the Medicaid fraction of the Medicare DSH payment adjustment, but instead included those days in the SSI or Medicare fraction.[1]

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]

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

[1] Request for Expedited Judicial Review Determination, Issue Statement, at 1 (Dec. 30, 2019), 15-1138.
[2] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[3] *Id.*
[4] *See* 42 U.S.C. § 1395ww(d)(5).

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:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were *entitled to benefits under part A* of this subchapter . . . .[9]

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:

> [T]he 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]

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

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

[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.*
[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

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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[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 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*

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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.

> *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"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[23]

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.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] *Id*. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[26] 863 F.3d 937 (D.C. Cir. 2017).
[27] *Id.* at 943.
[28] *Id.* at 943-945.

Provider's Request for EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[29] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[30] The Provider points out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

In this case, the Provider contends 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 Provider seeks a ruling on the procedural and substantive validity of the regulation announced in the FFY 2005 Final Rule that the Board lacks the authority to grant. The Provider maintains that since the Secretary has not acquiesced to the decision in *Allina I*, 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.

Jurisdiction

The participant addressed in this EJR determination has filed an appeal involving fiscal year 2012. [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

[29] 69 Fed. Reg. at 49,099.
[30] *Allina* at 1109.
[31] The appeal was filed on January 20, 2015, with eight issues, including the Part C days issue. On September 16, 2015, the two relevant Part C days issues were transferred to separate CIRP groups, PRRB Case Nos. 15-3384GC and 15-3385GC. On November 22, 2019, both issues were returned to the original individual appeal after the Provider notified the Board that there was only a single participant in each of the CIRP groups established for the issues and certified that there would be no other participants. Rather than convert the cases to individual appeals, the MAC requested that the group issues be transferred back to the Provider's individual appeal, a transfer to which the Board agreed.
[32] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp. v. Burwell* ("*Banner*").[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 largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the participant's appeal involved with the instant EJR request is governed by the decision in *Bethesda* and CMS-1727R as the Provider is challenging 42. C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) which mandate how Part C days are used in the DSH calculation. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal[35] and that the appeal was timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

Accordingly, the Board finds that it has jurisdiction for the referenced participant and the issue under appeal.

Board's Analysis Regarding the Appealed Issue

The appeal in this case 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 (with a minor revision published in the FFY 2011 IPPS final rule). The Board recognizes that, for the time period at issue in this request, 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

[33] 201 F. Supp. 3d 131 (D.D.C. 2016)
[34] *Id.* at 142.
[35] *See* 42 C.F.R. § 405.1837.

guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[36] 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 Provider would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[37]

Board's Decision Regarding the EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participant in the individual appeal is entitled to a hearing before the Board;

2) Based upon the participant's 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) (2011) 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) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The participant has 60 days from the receipt of this decision to institute the appropriate action for judicial review. This appeal contains additional issues under dispute, outside the scope of this EJR determination, and this case will remain open.

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:

1/23/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc.

[36] *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).
[37] *See* 42 U.S.C. § 1395oo(f)(1).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue***
Blumberg-Ribner 00 Dual Eligibles Group for FYs 1999 and 2000
Case No. 05-2280G

Dear Mr. Blumberg and Ms. VanArsdale,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' May 27, 2016 Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue for the Blumberg-Ribner 00 Dual Eligibles Group encompassing fiscal years ("FYs") 1999 and 2000. As set forth below, the Board denies this request because the Provider submitted it *well beyond* the three-year limit in the Board's rules for requesting reinstatement of an issue.

Background

On December 1, 2011, the Board issued a standard remand in Case No. 05-2280G and remanded the dual eligible Part A days issue to the Medicare Contractor, pursuant to the Centers for Medicare & Medicaid Services (CMS) Ruling 1498-R.[1] Accordingly, concurrent with the remand, the Board closed the case on December 1, 2011.

On May 27, 2016 (roughly 4 ½ years later), the Providers filed a Request for Rescission of Remand and Bifurcation of Group Appeal Regarding Disproportionate Share Hospital (DSH) Part C Days Issue. The Group Representative acknowledges that the Board remanded the Providers' appeal of the dual eligible days issue. However, the Group Representative asserts that "the Providers' appeal of the 'dual eligible days' . . . was intended to refer to persons eligible for Medicare Parts A ***and*** C" and that "[a]ccordingly, and based on numerous decisions of the Board, the dual eligible days issue did not come within the scope of Ruling 1498-R." The Providers

[1] Ruling 1498-R was issued on April 28, 2010, by the CMS Administrator to address three specific issues regarding the calculation of the Medicare disproportionate share hospital (DSH) payment adjustment: (1) the Medicare SSI fraction data matching process issue and the method for recalculating the hospital's Medicare SSI fraction, (2) the exclusion from the DSH calculation of non-covered patient hospital days for patients entitled to Medicare Part A including days for which the patient's Part A inpatient hospital benefits were exhausted for cost reporting periods before October 1, 2004, and (3) the exclusion from the DSH calculation of the labor/delivery room (LDR) inpatient days.

request that the Board rescind its remand and reinstate its appeal of the dual eligible days issue.[2] The Providers request that the Board reinstate the appeal for purposes of appealing the DSH Part C days issue.[3]

Decision of the Board

Board Rule 46.1 (effective July 1, 2015) specifies that "[a] Provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case." This Board Rule is consistent with 42 C.F.R. § 405.1885(b)(2)(i) which specifies that "[a] reopening made upon request is timely only if the request to reopen is received by . . . [the] or reviewing entity . . . no later than 3 years after the date of the determination or decision that is the subject of the requested reopening."

In the instant case, the Providers are requesting that the Board rescind its remand and reinstate its appeal of the dual eligible days issue. As previously noted, the Board closed Case No. 05-2280G on December 1, 2011 when the Board issued its decision remanding the dual eligible Part A days issue pursuant to Ruling 1498R. The Providers did not file their Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue until May 27, 2016 which is *roughly 4 ½ years after the case was closed*. Pursuant to 42 C.F.R 405.1885(b)(2) and Board Rule 46.1, the deadline for requesting reinstatement of the dual eligible issue was November 30, 2014 (three years from the date of the Board's decision dismissing/remanding the dual eligible days issue). The Providers' request to rescind and reinstate is ***well beyond*** the three year limit in the Board's Rules for requesting reinstatement of an issue. As such, the Board hereby denies the Providers' request to rescind and reinstate.

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:

1/28/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[2] Provider's Request for Rescission of Remand and Bifurcation of Group Appeal Regarding DSH Part C Days Issue at 1.
[3] *Id.* at 2.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Sven Collins, Esq.
Squire Patton Boggs (US) LLP
1801 California St., Ste. 4900
Denver, CO 80202

RE: ***EJR Determination for Part C Days Medicaid and Medicare Proxy Groups***
Patton Boggs Part C Days Medicaid and Medicare/SSI Fraction Groups
Case Nos. 13-3518GC, *et al.* (*see* attached list)

Dear Mr. Collins:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' January 8, 2020, Requests for Expedited Judicial Review ("EJR") of the above referenced twelve (12) appeals. The Board's jurisdictional determination and decision regarding the EJR requests is set forth below.

Issue in Dispute

The relevant issue in these twelve (12) appeals is:

> **Medicaid Fraction**: Whether CMS reimbursed the Providers for the full amount of the Medicare DSH supplemental payments to which they are entitled as a result of CMS's erroneous regulation and policy to treat dual eligible Part C enrollees as "entitled to benefits under Part A" and thus excluded from the numerator of the Medicaid fraction;
>
> And,
>
> **Medicare/SSI Fraction**: Whether CMS reimbursed the Providers for the full amount of the Medicare DSH supplemental payments to which they are entitled when CMS erroneously treated Part C enrollees as "entitled to benefits under Part A" and, thus, included Part C patient days in the numerator and the denominator of the Medicare/SSI fraction.[1]

[1] Renewed Consolidated Request for Expedited Judicial Review, at 2 (Jan. 8, 2020), PRRB Case No. 13-3518GC; *See id.* at Case Nos. 13-3518GC, 13-3521GC, 13-3856GC, 13-3857GC, 14-0909GC, 14-0911GC, 14-4021GC 14-4022GC, 14-4281GC, 14-4282GC, 15-3367GC, 15-3368GC.

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]

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 . . . .[9]

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]

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

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

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

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

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[13] 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

[11] Emphasis added.
[12] 42 C.F.R. § 412.106(b)(4).
[13] of Health and Human Services.

> 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]

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 Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[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*

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[14] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[15] *Id.*
[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.

> *under Medicare Part A. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.*[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"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[23]

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.

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[20] *Id.* (emphasis added).
[21] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[22] *Id*. at 47411.
[23] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[24] 746 F. 3d 1102 (D.C. Cir. 2014).
[25] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal

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 EJR

In the FFY 2005 Final Rule, the Secretary announced a policy change. This policy was to include Part C days in the Medicare Part A/SSI fraction and exclude them from the Medicaid fraction effective for discharges on or after October 1, 2004.[29] In *Allina I*, the Court affirmed the district court's decision "that the Secretary's final rule [for FFY 2005] was not a logical outgrowth of the proposed rule [for FFY 2005]."[30] The Providers point out that because the Secretary has not acquiesced to the decision, the regulation announced in the FFY 2005 Final Rule requiring Part C days be included in the Part A/SSI fraction and removed from the Medicaid fraction remains in effect as later set forth in 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).

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

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.
[29] 69 Fed. Reg. at 49,099.
[30] *Allina* at 1109.

Jurisdiction

The participants addressed in this EJR determination have filed appeals involving the 2007 to 2013 fiscal years.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[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 largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

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[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.

As set forth below, the Board finds that it has jurisdiction for the referenced appeals and the underlying participants.

A. Jurisdiction for Providers Appealing Non-issuance of an NPR

The providers participating in Cases 13-3856GC, 13-3857GC, 14-4021GC, 14-4022GC, 15-3367GC, and 15-3368GC initially appealed on the basis of the MAC's failure to timely issue NPRs. In three of these cases, namely Case Nos. 13-3856GC, 13-3857GC, and 14-4022GC, NPRs were ultimately issued for at least one of the providers, and that NPR was timely appealed within the same existing group.

Pursuant to 42 C.F.R. § 405.1835(c) a provider has the right to a hearing where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, 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 issuance of the final contractor determination . . .

In conjunction with the promulgation of these regulations, the Board issued the following instructions[36] for appeals filed from the non-issuance of NPRs, requiring the following information be submitted with hearing requests:

> 7.4 – Failure to Timely Issue Final Determination If your appeal is based on the failure of the Intermediary to timely issue a final determination, provide a copy of:
>
> • the certification page of the perfected or amended cost report,
>
> • the certified mail receipt evidencing the Intermediary's receipt of the as-filed and any amended cost reports,

[36] *See* PRRB Board Rules (Aug. 29, 2018).

> • the [Medicare Administrative Contractor (MAC)] letter/e-mail acknowledging receipt of the as-filed and any amended cost reports,
>
> • evidence of the [MAC's] acceptance or rejection of the as-filed and any amended cost reports . . .[37]

Board Rule 21.2.2 requires the same documentation be placed under Tab A of the jurisdictional documents that accompanies the Schedule of Providers.

In this case, all of the non-issuance group appeals exceed $50,000, and each provider timely filed within 180 days of the 12-month window of the failure to issue an NPR.[38] The Providers' documentation demonstrates that the timely filing requirements of the regulation have been satisfied and the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[39] Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying participants. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Jurisdiction for the Remaining Providers

The Board has determined that the ***remaining*** participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda* and CMS-1727R since the Providers are challenging a regulation. Each remaining Provider appealed from an original NPR. In addition, the remaining participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[40] and that 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.

Board's Analysis Regarding the Appealed Issue

The twelve (12) appeals covered by these EJR requests involve the fiscal year 2007 to 2013 cost reporting periods (all with a fiscal year ending September 30th). 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 FFY 2008 IPPS final rule (with a minor revision published in the FFY 2011 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

[37] PRRB Board Rules effective March 1, 2013.
[38] *See* 42 C.F.R. § 405.1835(c).
[39] *See* 42 C.F.R. § 405.1837.
[40] *See* 42 C.F.R. § 405.1837.

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.

Board's Decision Regarding the EJR

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in the individual 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) (2011) 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) (2011) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the EJR for the issue and the subject years. The participants 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. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

1/31/2020

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc.

[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).

Appendix A

13-3518GC	Patton Boggs 2009 DSH Medicare Part C/Part A Days Medicaid Fraction - Lee Memorial CIRP Group
13-3521GC	Patton Boggs 2009 DSH Medicare Part C/Part A Days Medicare Fraction - Lee Memorial CIRP Group
13-3856GC	Patton Boggs 2011 Lee Memorial Medicare Part C/Part A Days Medicaid Fraction CIRP
13-3857GC	Patton Boggs 2011 Lee Memorial Medicare Part C/Part A Days Medicare Fraction CIRP
14-0909GC	Patton Boggs 2007- 2008 DSH Lee Memorial-Medicaid Fraction-Medicare Part C/Part A CIRP Group
14-0911GC	Patton Boggs 2007- 2008 Lee Memorial Medicare Fraction Part C/Part A CIRP Group
14-4021GC	Squire Patton Boggs 2012 DSH Medicare Part C Days/Medicaid Fraction - Lee Memorial CIRP Group
14-4022GC	Squire Patton Boggs 2012 DSH Medicare Part C Days/Medicare Fraction - Lee Memorial CIRP Group
14-4281GC	Squire Patton Boggs 2010 DSH Medicare Part C/Part A Days Medicaid Fraction - Lee Memorial NPR CIRP Group
14-4282GC	Squire Patton Boggs 2010 DSH Medicare Fraction Part C/Part A Days Medicare - Lee Memorial NPR CIRP Group
15-3367GC	Squire Patton Boggs - Lee Memorial 2013 Medicare Fraction Part C Days CIRP
15-3368GC	Squire Patton Boggs - Lee Memorial 2013 DSH Medicaid Fraction Part C Days CIRP

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

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RE: ***EJR Determination***
George Washington University Hospital (Prov. No. 09-0001)
FYE 12/31/2015
Case No. 19-1586

Dear Mr. Henefer:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's November 19, 2019 request for expedited judicial review ("EJR") (received November 20, 2020) and the Provider's January 6, 2020 response (received January 7, 2020) to the Board's December 11, 2019 letter seeking additional information relating to corporate ownership. In this regard, the Board had noted that the Provider was owned by Universal Health Services ("UHS") and asked if a mandatory group appeal as required by 42 C.F.R. § 405.1837(b)(1)(i) should be established. The Provider Representative certified that UHS does not own any other hospitals that could file an appeal of the DGME issue for this fiscal year. The decision of the Board with respect to EJR is set forth below.

Issue in Dispute

In this case, the Provider is challenging:

> . . . the validity of the formula contained in 42 C.F.R. § 413.79(c)(2)(iii) for calculating the number of full-time equivalents ("FTE") residents a hospital may count in a year for the purposes of direct graduate medical education ["DGME"] reimbursement. [The Provider contends that the] formula is unlawful because it conflicts with the Medicare statute and is arbitrary and capricious because it penalizes hospital's that train "fellows" (*i.e.* residents who are not in their initial residency period) while operating in excess of the FYE caps.[1]

[1] Provider's EJR request at 1.

Background

The Medicare statute requires the Secretary[2] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [3] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[4]

The Medicare statute prescribes a formula for computing annual DGME payments to hospitals. The statutory formula consists of three components:

1. The hospital's number of FTE residents, or "FTE count;"
2. The hospital's average cost per resident (*i.e.* the per resident amount or "PRA"); and
3. The hospital's patient load, which is the percentage of a hospital's inpatient treatment days attributable to Medicare Part A and Part C beneficiaries.[5]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

A hospital's FTE count for DGME reimbursement is the number of residents trained at the hospital as adjusted by three statutory provisions. First, the statute, 42 U.S.C. 1395ww(h)(4)(C), assigned different weights to residents depending on their status. The statute states that:

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
>
> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
>
> (iv) . . .for a resident who is not in the resident's initial residency period . . . the weighting factor is .50.

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[6] ("*IRP residents*") are weighted at 100 percent or 1.0 while FTEs attributable to residents who are not in their initial residency period (commonly referred to as "*fellows*") are weighted at 50 percent or 0.5. The sum of the weighted FTEs for IRP residents and fellows in a given year is known as a hospital's "weighted FTE count." For example, under this weighting

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[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[7] which added 42 U.S.C. § 1395ww(h)(4)(F) to establish a limit on the number of osteopathic and allopathic residents that a hospital can be included in its FTE count for DGME payments. For cost reporting periods beginning on or after October 1, 1997, a hospital's unweighted DGME FTE count could not exceed the hospital's unweighted FTE count for its most recent cost reporting period ending on or before December 31, 1996. In this regard, § 1395(h)(4)(F)(i) states:

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

Further, 42 U.S.C. § 1395ww(h)(4)(G)(i) provides that residents are counted on a three year average. Finally, 42 U.S.C. § 1395ww(h)(4)(A) directs the Secretary to "establish rules consistent with [§ 1395ww(h)(4)] for the computation of the number of full-time equivalent residents in an approved medical residency training program."

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[9] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.

[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> •*Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[13] This regulation is the focus of these appeals and this EJR request, and it states the following:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonresidents, respectively, will be reduced in the same proportion that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.

As previously noted, this regulation addresses how to reduce a hospital's weighted FTE count for a fiscal year when the unweighted FTE count for that fiscal year exceeds the hospital's unweighted FTE cap.

On their cost reports, hospitals report the number of allopathic and osteopathic FTE residents (before applying the weighting factors mentioned above) that were actually trained at the facility that year.[15]

In addition, the statute sets the number of FTEs a hospital can claim for reimbursement as the hospital's average FTE count between the present, prior and penultimate years. The statute states:

> [T]he total number of full-time equivalent residents for determining a hospital's graduate medical education payment shall equal the average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[16]

Therefore, a hospital's present year FTE count, after applying the weighting factors and FTE caps, is averaged with the FTE counts from the prior and penultimate years.

The Provider's Position

The Provider contends that the Secretary's regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the regulation produces absurd result. If a hospital is training residents in excess of its cap, and some of its residents are fellows, under the regulation each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Provider believes that the Secretary's regulation is arbitrary and capricious, in excess of statutory authority and should be held as unlawful by a reviewing court.

The Provider asserts that the regulation—as applied to hospitals that train fellows—conflicts with the Medicare statute which is designed to compensate hospitals based on their costs, including DGME costs. The regulation, the Provider argues, punishes hospitals which are above their cap and train fellows by ensuring that they do not receive reimbursement to which they are entitled under the statute.

The Provider believes that since the Board has jurisdiction over the appeal, but lacks the authority to grant the relief sought—(a) to find that the formula prescribed by 42 C.F.R. § 413.79(c)(2)(iii) is unlawful; and (b) to compel the Secretary to pay the Provider reimbursement that was withheld as a result of the regulation—EJR is appropriate.

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[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(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.

The participant in this this EJR request has filed an appeal involving fiscal year 2015.

A. Jurisdiction

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[17] 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.[18]

On August 21, 2008, new regulations governing the Board were effective.[19] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hosp.l v. Burwell (Banner).*[20] 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.[21]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare

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[17] 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.).
[18] *Bethesda at 1258-59.*
[19] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[20] 201 F. Supp. 3d 131 (D.D.C. 2016)
[21] *Banner* at 142.

Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board finds that the DGME reimbursement question is controlled by 42 C.F.R. § 413.79(c)(2)(iii) which is a regulation that the Providers are challenging and that left the Medicare Contractors without the authority to make the payment in the manner sought by the Provider in this case. Consequently, the Board finds that the appeal is governed by CMS Ruling CMS-1727-R and it has jurisdiction over the Provider in this case. In addition, the participant's documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[22] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount.

B. Board's Analysis of the Appealed Issue

The Provider asserts that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Provider asserts that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Provider presents the following equation in their request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [23]

Accordingly, the Board set out to confirm the Provider's assertion that § 413.79(c)(2)(iii) does in fact set forth the above equation.

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[24] As such, the equation would logically appear to be a

[22] *See* 42 C.F.R. § 405.1835(a)(2).
[23] EJR Request at 4.
[24] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[25] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the Providers that § 413.79(c)(2)(iii) essentially states the above equation, albeit in a slightly different form where the difference is inconsequential and it gives the same results. In its entirety, § 413.79(c)(2)(iii) states:

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[26]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[27] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[28] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the

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limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

[25] 66 Fed. Reg. at 39894 (emphasis added).

[26] (Emphasis added.)

[27] *See* 62 Fed. Reg. at 46005 (emphasis added).

[28] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).

operation of the following simple algebraic principle of equivalent fractions[29] (*i.e.*, ratios) using variables a, b, c, and d:

$$If\ \frac{a}{b} = \frac{c}{d}\ then\ \ c = \frac{a}{b}\ x\ d$$

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[30]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same proportion." This phrase expressed as a ratio ("c/d") is an *unknown* Weighted FTE Cap over the FY's Weighted FTE Count. In other words, the unknown Weighted FTE Cap is the resulting value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

$$\frac{Weighted\ FTE\ Cap\ (c)}{FY's\ Weighted\ FTE\ Count\ (d)} = \frac{Unweighted\ \ FTE\ Cap\ (a)}{FY's\ Unweighted\ FTE\ Count\ (b)}$$

The unknown Weighted FTE Cap (variable "c") is then determined by a/b x d. In other words, the unknown Weighted FTE Cap is determined by the following formula:

$$\boldsymbol{Weighted\ FTE\ cap} = \frac{Unweighted\ \ FTE\ Cap}{Unweighted\ FTE\ Count} \times\ Weighted\ FTE\ Count$$

This formula is clearly stated in the preambles to both the FYs 1998 and 2002 IPPS Final Rules as previously quoted.

Based on the above, the Board finds that 42 C.F.R. § 413.79(c)(2)(iii) does set forth the equation being challenged and, accordingly, that the Provider is challenging the validity of § 413.79(c)(2)(iii). Since 42 C.F.R. § 405.1867 requires that the Board comply with the requirements of the statute and regulations, the Board lacks the authority to eliminate the regulatory provision that creates the alleged penalty in § 413.79(c)(2)(iii) which is the remedy

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[29] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

[30] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

the Provider is seeking. Consequently, EJR is appropriate for the issue under dispute in thus case.

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 participant in this appeal is entitled to a hearing before the Board;

2) Based upon the participant's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), 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. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(ii)-(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 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 the 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:

1/31/2020

X Clayton J. Nix

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

cc: Bruce Snyder, Novitas
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Andrew Dreyfus
HealthQuest Consulting, Inc.
161 Fashion Lane, Suite 202
Tustin, CA 92780

RE: ***Motion to Reinstate Withdrawn Case***
Ronald Reagan UCLA Medical Center (Prov. No. 05-0262)
FYE 06/30/2006
Case No. 17-0666

Dear Mr. Dreyfus,

The Provider Reimbursement Review Board ("Board") has reviewed the Motion to Reinstate Withdrawn Case submitted on December 13, 2019. The decision of the Board is set forth below.

Background

Ronald Reagan UCLA Medical Center ("Provider") filed an Individual Appeal Request on December 15, 2016 from a Notice of Program Reimbursement ("NPR") dated July 14, 2016, for fiscal year ending June 30, 2006. On November 20, 2019, the Provider withdrew its appeal after transferring the only remaining issues, Part C Days, to Case Nos. 17-1250GC and 17-1248GC. The Provider's Motion to Reinstate was submitted in writing within three years.

The Provider states that it received a draft Administrative Resolution ("AR") from the Medicare Contractor on October 9, 2019 and mistakenly concluded that the AR had been fully executed and completed. It was only after the Provider was notified by the Medicare Contractor that it realized its error. The Provider explains that, while the AR is now complete awaiting final approval from Federal Specialized Services, it is necessary for the subject appeal to be reinstated in order to execute and implement the AR.

Board Decision

Board Rule 46 states the following regarding withdrawal:

> A provider's request to withdraw an issue(s) or case must be in writing. It is the provider's responsibility to withdraw: (1) an issue(s) or case that the provider no longer intends to pursue; (2) an issue(s) or case ***in which an administrative resolution has been executed and attach a copy of such administrative resolution***; (3) an issue(s) for which the Medicare contractor has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Medicare contractor where the Medicare contractor agreed to that reopening; (4) all issues in a case where the

> provider intends to pursue reopening simultaneously with the appeal request (*see* Rule 47.2.3); and (5) a case in which all issues have been handled, whether by resolution, transfer, dismissal, or withdrawal.
>
> When a provider notifies the Board that it is withdrawing an issue(s), the provider's notification must: (1) describe the specific issue(s) being withdrawn; (2) address whether the withdrawal is conditioned/dependent on the Medicare contractor's action through an administrative resolution or reopening; and (3) confirm whether there are any other issues remaining in the case and, if so, provide the status on each remaining issue. Note that the Board will not issue a decision to acknowledge the withdrawal of an issue(s) if the withdrawal does not result in the closure of the case.[1]

Following such a withdrawal, Board Rule 47.1 permits a provider to file a motion for reinstatement within three years of withdrawing the appeal or issue.[2] The motion must be in writing setting out the reasons for reinstatement.[3]

In this case, the Provider withdrew its case without qualification and without reference to the alleged AR in contravention to Board Rule 46. Based on the request for reinstatement, it appears that the Provider prematurely withdrew this appeal without a fully executed and complete AR. If true, this is clearly an oversight by the Provider. In this regard, Rule 47.1 specifically states: "The Board will not reinstate an issue(s)/case if the provider was at fault." Further, Rule 47.3 states: "Generally, administrative oversight, settlement negotiations . . . will not be considered good cause to reinstate." Accordingly, the Board hereby denies the request for reinstatement because the Provider's request to withdraw the appeal was premature based on an administrative oversight as the AR had not yet been fully executed. Case No. 17-0666 remains closed.

Board Members Participating:

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Gregory H. Ziegler, CPA, CPC-A
Robert A. Evarts, Esq.
Susan A. Turner, Esq.

For the Board:

1/31/2020

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators

[1] (Emphasis added.)
[2] Board Rule 47.1.
[3] *Id*.