DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

Stephanie Webster, Esq.
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2099 Pennsylvania Ave., NW
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RE ***EJR Determination***
University of Michigan Hospitals & Health Centers (Prov. No. 23-0046)
FYE 6/30/2015
Case No. 20-1772

Dear Ms. Webster:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's December 6, 2021 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[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;"

[1] Provider's EJR request 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).

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 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

[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).

> 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. . . .
>
> 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

[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).

> 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:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus

[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 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]

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]

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

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 is requesting the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the DGME cap on full-time equivalent ("FTE") residents and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[17] The Provider explains that it is a teaching hospitals that receive DGME payments, and that during the cost year in dispute, its unweighted FTE count exceeded it FTE cap. It also trained fellows and other residents who were beyond their initial residency period ("IRP").[18]

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[19] Instead, a weighted FTE cap is determined 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,[20] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Provider contends that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[21]

Second, the Provider argues, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Provider explains that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Provider concludes that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since the Board lacks the authority to grant the relief sought, the Provider requests that EJR be granted.

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[17] Provider's Petition for Expedited Judicial Review at 1 (Dec. 6, 2021) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[18] *Id.* at 7.
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[21] *Id.* at § 1395(h)(4)(F)(i).

The Medicare Contractor has not filed a response to the EJR Request and the time for doing so has elapsed.[22]

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) (2019), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

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

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

On August 21, 2008, new regulations governing the Board were effective. 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"). 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.

[22] PRRB Rule 42.4 (2021).

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

The Board has determined that the Provider in Case No. 20-1772 involved with the instant EJR request involves a cost report period which began prior to January 1, 2016 and is governed by CMS Ruling CMS-1727-R. The Board found that it has jurisdiction pursuant to this Ruling because the Provider is challenging a regulation and administrative review of that challenge is not precluded by statute or regulation. In addition, the Provider's jurisdictional documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal. The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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 Providers present 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

[23] EJR Request at 4.

[weighted] FTE count" for the FY.[24] 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.[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 Provider 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

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[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 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.)).

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[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 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 year and that the Provider in this appeal is entitled to a hearing before the Board;

2) Based upon the Provider'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)(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 other issues remain in this case, it will remain open. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

FOR THE BOARD:

1/3/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators.
Wilson Leong, FSS

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RE: ***Reinstatement Decision***
Sharp HC FFY 2002 DSH - Dual Eligible Days Group
Case No. 10-1195GC

Dear Mr. Reid and Ms. Frewert:

This common issue related party ("CIRP") group case involves the appeal of the participants' Medicare reimbursement for the fiscal year ending ("FYE") in 2002. As explained below, the Provider Reimbursement Review Board ("Board") *grants in part and denies in part* the Provider Representative's Reinstatement Request of the Board's August 18, 2015 decision to dismiss the following two (2) providers from the instant appeal:

1. Sharp Memorial Hospital ("Memorial"): and
2. Sharp Chula Vista Medical Center ("Chula Vista").

Pertinent Facts

On August 18, 2015, the Board issued a decision in which it dismissed Memorial from the appeal for lack of jurisdiction and remanded the dual eligible days issue for Chula Vista pursuant to CMS Ruling 1498-R. As set out within this determination letter, the Board also found that the Part C days issue was not properly pending in the group appeal and, therefore, dismissed the issue and closed the appeal.[1]

Subsequently, *almost three years later*, on August 15, 2018, the Provider Representative filed a reinstatement request. In the request, the Provider Representative requests that the Board vacate its August 18, 2015 rulings relating to Memorial and Chula Vista. The Providers argue that the Medicaid Eligible Day issue was included in their respective individual appeals and was appropriately transferred to Case No. 10-1195GC. Therefore, they assert that the Board should not have dismissed Memorial's exhausted Part A days and Part C days from Case No.

[1] Board Letter dated August 18, 2015, Reinstatement Request at Exhibit P-1.

10-1195GC and should not have dismissed Chula Vista's Part C days from Case No. 10-1195GC.[2]

A. Pertinent Facts for Memorial

On November 28, 2007, Memorial was issued a Notice of Program Reimbursement.[3] On May 19, 2008, Memorial filed its individual appeal with the Board (Case No. 08-1937) and included the following issue in its appeal request which the Provider states is the "Medicaid eligible days" issue:

> **Issue 1 – Disproportionate Share Hospital Adjustment – CMS Days**
>
> ***
>
> **Findings of Fact**:
> The Medi-Cal days are used to determine DSH. The intermediary *eliminated* County Medical Service days as non Medi-Cal days.
>
> ***
>
> **Provider Position and basis for contending that the findings and conclusions are incorrect**:
> The Provider claims *the County Medical Services* days are low-income patients funded by the states Medi-Cal system or under a 1115 Waiver program and should be included in the eligible days. The PPS payments and 100% federal Capital PPS payments must be adjusted based on the final DSH percentage. Congressional intent was to include all low income patients in the proxy to determine additional DSH funding.[4]

On October 18, 2008, Memorial added the following issue to its individual appeal:

> 1. A brief description of the issue:
> Whether the California Department of Health Services reported all Title XIX Medi-Cal patients to the provider when requested. *The provider contends that there are **Medi-Cal aid codes***, restricted or otherwise and possibly ***under the 1115 Waiver program***, *that are federally funded under Title XIX but are **not** included in the data requested by the provider for Disproportionate Share Hospital Adjustment calculations*. For example, Aid codes OA, 01, 02, 08, 8N, and 8T are believed to be federally funded under Title XIX but

[2] Reinstatement Request at 1-2, August 13, 2018.
[3] Reinstatement Request at Ex. P-8.
[4] *Id.* at Ex. P-2 (italics emphasis added).

> are not included in the ***eligible days*** provided by the California Department of Health to he [*sic* the] provider.[5]

Next, on July 27, 2010, Memorial requested to transfer the following issue to this group, Case No. 10-1195GC:

> Whether the Medicare Benefit Exhausted patient days eligible for Medi-Cal and the Medicare Advantage (MA+C) days should be included in the Medicaid ratio, the Medi-Caid ratio, or excluded from the Disproportionate Share Hospital (DSH) Adjustment.[6]

B. Pertinent Facts for Chula Vista

On September 26, 2006, Chula Vista was issued an NPR. On March 22, 2007, Sharp Chula filed its individual appeal with the Board and included the following issue:

> **Excluded Dual Eligible Days for Disproportionate Share calculations**
>
> **Findings of Fact:**
>
> The Centers for Medicare and Medicaid Services (CMS) instructions to determine the DSH adjustment require providers to exclude Medi-Cal eligible patient days if a patient is also entitled to Medicare Part A benefits.
>
> **Provider Position and basis for contending that the findings and conclusions are incorrect:**
>
> The provider claims that patients entitled to Medicare part A and Medicaid (dual eligible claims) *that have not been included in the SSI entitled Medicare patient days* should be examined to determine if they are entitled to SSI and included in the SSI percentage if determined to be SSI entitled. If the claims are not entitled to SSI but are eligible for Medicaid, regardless of whether or not they are entitled to Medicare Part A benefits during their hospital stay, they should be included in the Medicaid percentage of the DSH adjustment. In addition, claims where Medicare benefits are exhausted should be included in the Medicaid percentage if they are not SSI entitled. . .[7]

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[5] *Id*. at Ex. P-2 (emphasis added).
[6] *Id*. at Ex. P-10.
[7] *Id*. at Ex. P-4 (italics and underline emphasis added).

On July 27, 2010, Chula Vista requested to transfer an issue to this group, Case No. 10-1195GC and identified this issue as the "Medicare Advantage and Medicare Advantage days" issue. As noted in the Board's initial denial letter, included at Exhibit 1, the transfer request stated:

> The Provider requests to transfer the issue of Medicare Dual Eligible Days to a Group Appeal from the above referenced individual appeal of the Provider to a group appeal. The issue to be transferred is Issue 4:
>
> Whether the Medicare Benefit Exhausted patient days eligible for Medi-Cal and the Medicare Advantage (MC+C) days should be included in the Medicare ratio, the Medicaid ratio, or excluded from the [DSH] Adjustment.

C. Memorial and Chula Vista's Request for Reinstatement:

The Providers argue that the issue was appropriately transferred from each of the individual appeals of Medicaid Eligible days issue and that these proper transfers were submitted on July 27, 2010. The Providers recognize that the Board revised its rules in August 2008 to require more specific pleading of sub-issues of the DSH adjustment; however, they note that those rules were not in effect as of May 19, 2008 and March 22, 2007, when the Providers filed their individual appeal requests. They argue that Part C days refer to Medicare patients who while "eligible" for Part A, gave up their entitlement to Part A coverage by selecting coverage under Part C. When such patients are also Medicaid eligible, these days clearly constitute Medicaid eligible days.[8]

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2008), providers have a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if: (1) they are dissatisfied with their respective final determinations of the Medicare contractor; (2) the amount in controversy is $50,000 or more; and (3) the providers' requests for hearing are filed within 180 days of the date of receipt of their respective final determinations.

[8] Reinstatement Request at 4.

In the instant case, the Board received the group appeal request *on July 29, 2010*. The Board previously found that the Part C[9] days issue was not properly pending in this group appeal.[10] As set forth below, the Board upon reconsideration grants the Reconsideration Request with respect to Chula Vista but denies the Reconsideration Request with respect to Memorial.

A. Chula Vista:

When Sharp Chula filed its individual appeal on March 22, 2007 and when the group appeal was established on July 29, 2010, the Board recognizes that there had not yet been any litigation or other CMS issuances that made clear the separateness of the DSH Part C issues from the DSH dual eligible days issue.[11] This also involves a year prior to the FY 2005 IPPS Final Rule wherein CMS implemented its current policy of counting Part C days in the SSI fraction. As stated in the FY 2005 IPPS Final Rule, CMS' prior policy was not to count Part C days in the SSI fraction. Further, it is clear that the transfer request references Medicare Part C. Accordingly, *after taking that into account*, the Board now finds that there were two issues pending within the group appeal under Case No. 03-0419G, that Chula Vista appealed and transferred these same two issues into the group, and that the presence these two issues in the group violates 42 C.F.R. § 405.1837(a)(2) and Board Rule 13.[12] As a result, the Board grants the Reconsideration Request with respect to Sharp Chula Vista.

B. Memorial

The Board denies the Reconsideration Request with respect to Memorial. At the outset, the Board notes that the request for reconsideration does not include any additional evidence or documentation.

When Memorial filed its appeal, the regulation at 42 C.F.R. § 405.1841(a)(1) (2007) imposed the following requirements regarding the "content of request for Board hearing":

---

[9] 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. § 1394ww-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),k enacted on December 8, 2003, replaced the Medcicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[10] August 8, 2015 Board Decision.

[11] *See, e.g.*, *Northeast Hosp. Corp. v. Sebelius*, 699. Supp. 2d 81 (D.D.C. 2010), *aff'd by*, 657 F.3d 1 (D.C. Cir. 2011); *Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75 (D.D.C. 2012), *aff'd by*, 746 F.3d 1102 (D.C. Cir. 2014); *King & Spalding Inclusion of Medicare Advantage Days in 2007 SSI Ratios v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D38 (June 29, 2010) (This "D-" decision is an EJR determination. The Board does not routinely publish EJR determinations as "D-" decisions and will do so only when the EJR determination is *seminal*.).

12 42 C.F.R. § 405.1837(a)(2) provides that a provider has a right to a Board hearing as part of a group appeal if "[t]he matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." PRRB Rule 13 states, "[t]he matter at issue in a group appeal must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling." Both the regulation and Board Rule make it clear that a group appeal can only contain one issue.

> Such request for Board hearing ***must*** *identify the aspects of the determination with which the provider is dissatisfied*, ***explain why*** the provider believes *the determination is incorrect* in such particulars, ***and*** be accompanied by *any documenting evidence* the provider considers necessary to support its position.[13]

Similarly, when the Provider filed the appeal (as well as the alleged add issue request) the Board Rules in effect were issued on March 1, 2002. These Rules addressed the content of appeal request in Part I.B.II.a:

> Your hearing request must include an identification and statement of the issue(s) you are disputing. ***You must identify the specific issues, findings of fact and conclusions of law with which the affected parties disagree***; and you must specify the basis for contending that the findings and conclusions are incorrect. If you use an acronym, you must define it first. You must clearly and specifically identify your position in regard to the issues in dispute. *For instance, if you are appealing an aspect of the disproportionate share (DSH)* adjustment factor or calculation, do not define the issue as "DSH". *You must precisely identify the* ***component*** *of the DSH issue that is in dispute*. For Example: Were the Intermediary's adjustments to the number of available beds for disproportionate share (DSH) qualification purposes proper? Please note that because of space limitations, the Board cannot accept initial requests or subsequent submissions that are in loose-leaf three-ring binders. You should submit large or voluminous documents bound in a manner that requires less storage space.[14]

They specify at Part I.C.IV. that a request to add issues was subject to the above content requirements at Part I.B.II.a.

Unlike the appeal request of its sister CIRP provider, Chula Vista,[15] Memorial did not include any clear discussion or stated dispute of dual eligible days in either its appeal request or the alleged add issue request (*i.e.*, did not identify its dissatisfaction with either dual eligible days or Part C days). The Group Representative appears to concede that fact in its request for reconsideration but alleges that the four issues included in its appeal request were "broad enough" to encompass the dual eligible days and Part C days issues:

> Although the issue was ***not*** *described with particularity* as Medicare Part C days, or Part A Exhausted Days, an appeal of the

[13] (Emphasis added.)
[14] (Emphasis added.) (*Available at:* https://www.cms.gov/files/document/prior-prrb-rules-march-1-2002.pdf.)
[15] A comparison of the issue statements of Chula Vista to those of Memorial make this clear.

> Medicaid percentage of the DSH adjustment in 2007 was certainly *broad enough* to encompass both of those claims, in addition to other sub-issues.[16]

Notwithstanding, the Group Representative contends that the following statement in Memorial's add-issue request dated October 18, 2008 confirms that Memorial intended to dispute both dual eligible days and Part C days:

> If a patient is Medicaid "eligible," but is not "entitled" to benefits under Part A of Medicare **as a result of having exhausted his or her Part A benefits** for a particular level of service, the Medicaid-eligible patient day at issue fully qualifies under the statutory definition as a Medicaid-eligible day and should not be removed from the numerator of the equation." [Emphasis added.][17]

While the request for reconsideration included a copy of the alleged add-issue request, it does not include confirmation that the request was actually filed with the Board as required under Board Rule 21(B)(2) (in effect when the add-issue request was filed)[18] in order to establish jurisdiction over the provider. As a result, the Group Representative has failed to present sufficient evidence to establish that the alleged "add issue" was actually part of the individual appeal prior to being transferred to Case No. 10-1195GC.

Regardless, the Board further finds that the description of the potentially relevant issues in Memorial's individual appeal request (filed May 19, 2008) and request to add issues (allegedly filed October 18, 2008) is ***neither*** the dual eligible ***nor*** Part C days issue seeking to move those days from the SSI fraction to the Medicaid fraction. Instead, the Provider appealed two distinct Medicaid eligible days issues relating to including *in the Medicaid fraction* both "County Medical Service days" and certain "Medi-Cal aid codes, restricted or otherwise and possibly under the 1115 Waiver program, that are federally funded under Title XIX but are ***not*** *included* in the data requested by the provider for Disproportionate Share Hospital Adjustment calculations":

> 1. A brief description of the issue:
>
> *Whether* ***the California Department of Health Services*** *reported all Title XIX Medi-Cal Eligible patients to the provider when requested*. The provider contends that there are Medi-Cal codes, restricted or otherwise and possible under the 1115 Waiver program, that are federally funded under Title XIX but are not

[16] (Emphasis added.)
[17] Request for Reconsideration at 3 (quoting Memorial's add issue request but adding the bold and underline emphasis).
[18] The add issue request is considered and appeal of that issue. This Board Rule is now located at Board Rule 21.3.2.

> included in the data requested by the provider for Disproportionate Share Hospital Adjustment calculations. For example Aid codes OA, 01, 02, 08, 8N, and 8T are believed to be federally funded under Title XIX but are not included in the eligible days provided by the California Department of Health Services to he [*sic* the] provider.
>
> * * * *
>
> 3. Amount in controversy: $66,810 (TAB 3)
>
> 4. Legal Basis for the Appeal (Cite statutes and/or regulations and/or manual provisions.):

These Medicaid eligible days issues are clearly identified as the issue in dispute (*i.e.*, the component of the DSH calculation with which they are dissatisfied) and are separate issues from either the dual eligible or Part C days issues. As a result, the Board finds that these Medicaid eligible days issues cannot be construed under 42 C.F.R. § 405.1841(a)(1) (2007) and Board Rule Part I, B., II.,a. (March 1, 2002) to include either the dual eligible or Part C days issues. In making these findings, the Board notes that the above-quoted excerpt from Memorial's request to add issues simply reflects a statement of the law then in effect since, as explained in the preamble to the FY 2005 IPPS final rule, prior to October 1, 2004, the Medicare program and does not identify any dispute other than in the phrase "the Medicaid-eligible patient day at issue."

Finally, the July 27, ***2010*** transfer request that Memorial made to transfer into the group cannot, in and of itself, be considered a timely or proper request to add the Dual Eligible days and Part C Days issues to Memorial's individual appeal. As noted in the Board's initial August 18, 2015 dismissal of Memorial, 42 C.F.R. § 405.1835(c) (2008) specifies that issues must be added 60 days following the § 1835(a)(3) deadline to file an appeal before the Board.[19] As such, it is clear that the transfer request was made well after the deadline to add issues in Memorial's individual appeal.

* * * * *

In summary, the Board hereby reopens Case No. 10-1195GC ***solely*** in order to reinstate the Part C days issue for Sharp Chula Vista. *As the Board has not identified a 2002 Sharp CIRP group (whether open or closed) for the Part C issue*, the Board will transfer the Part C days issue for Sharp Chula Vista from Case No. 10-1195GC to a newly formed individual appeal; the case

[19] The Board further notes that 42 C.F.R. § 405.1835(c) (2008) was promulgated in the final rule published on May 23, 2008 and, in the preamble to that final rule, the Secretary explained how the regulatory change would be applied to then pending Board appeals: "For appeals pending before . . . the Board prior to the effective date of this rule [*i.e.*, August 21, 2008], a provider that wishes to add one or more issues to its appeal ***must*** do so by the expiration of the ***later*** of the following periods: (1) 60 days after the expiration of the applicable 180-day period prescribed in . . . § 405.1835(a)(3) (for Board hearings); or (2) 60 days after the effective date of this rule [*i.e.*, 60 days after August 21, 2008]." 73 Fed. Reg. 30190, 30236 (May 23, 2008).

number and case acknowledgement will be sent under separate cover. As there are no Providers that remain pending in the appeal, the Board hereby again closes Case No. 10-1195GC and removes it from the Board's docket.

Board Members Participating:

1/4/2022

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

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Hooper, Lundy & Bookman, P.C.
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Los Angeles, CA 90067

RE: ***Jurisdictional Decision***
Community Medical Center - Fresno (Prov. No. 05-0060)
FYE 8/31/2012
Case No. 15-3456

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents filed in the above captioned case. The Medicare Contractor has filed a Jurisdictional Challenge over two issues in the appeal, and the decision of the Board is set forth below.

Background

On September 30, 2015, the Board received Provider's Individual Appeal Request appealing their April 23, 2015 Notice of Program Reimbursement ("NPR") for fiscal year ending August 31, 2012. The initial appeal contained the nine (9) following issues:

1. Disproportionate share adjustment: SSI percentage[1]
2. Disproportionate share adjustment: Medi-Cal percentage, Medi-Cal dual-eligible days[2]
3. Disproportionate share adjustment: Medi-Cal Percentage – Medi-Cal unpaid eligible days
4. Medicare regular bad debts
5. IME & DGME Current Year Resident FTE Counts – Didactic Time[3]
6. Prior Year & Penultimate Year IME & DGE Resident FTE Counts
7. IME Prior Year "r"
8. Capital DSH and IME Payments
9. Pharmacy Residency Program

On November 23, 2015[4] the Provider filed a request to add the following issue:

10. Disproportionate share adjustment: Calculation of the Medicaid Fraction not to include Labor Room Days twice in the denominator ("L&D Days Issue")

[1] The Provider withdrew this issue on April 15, 2021.
[2] Transferred to case 15-2412GC on October 16, 2015.
[3] In its response to a jurisdictional challenge, the Provider withdrew this issue on June 22, 2018.
[4] The Provider filed a second, identical request for the same issue on December 21, 2015.

In its initial appeal request, the Provider described its Issue 9: Pharmacy Residency Program issue as follows:

> It is the Provider's contention that the Provider's Pharmacy Residency Program meets all criteria requirements pertinent to the qualification of approved nursing an dallied health education program costs for pass-through cost reimbursement as outlined in 42 C.F.R. § 413.85(f). However, the MAC treated the Pharmacy Residency Program's applicable costs as educational activities that are part of normal Pharmacy operating costs and therefore did not afford the Provider the pass-through reimbursement treatment to which it was entitled. The MAC's determination should be reversed because the Provider met the applicable requirements in the relevant regulation for special reimbursement treatment with respect to its Pharmacy Residency Program.

In its request to add the issue, the Provider described its Issue 10: DSH: Calculation of the Medicaid Fraction not to include Labor Room Days twice in the denominator Issue as follows:

> Days associated with the time patients spent in the hospital Labor Room were erroneously included twice in the Total Days (1,817) component of the calculation for the Provider's entitlement to payment as a Disproportionate Share Hospital (DSH). The cost report Worksheet S-3 Part I Column 8 line 14 identifies total days, and based from [sic] the hospital's census work paper included Labor & Delivery days. The Provider also is required to identify Labor and Delivery days specifically on Worksheet S-3 Part I line 32 column 9. The cost report includes a Worksheet to help calculate the allowable DSH percentage to be reported on Worksheet E Part A line 33, however, the DSH Worksheet calculation does not provide a mechanism to exclude Labor & Delivery days (as reported on S_3 Part I line 32 column 8) if Labor & Delivery days are already included in Total Days (as is the case with this Provider). In this regard reporting Labor & Delivery days on Worksheet S-3, Part I, line 32, column 8 actually doubles the number of Labor & Delivery days in the allowable DSH percentage calculation. The Provider contends the Labor and Delivery days reported on S-3 Part I line 32 column 8 should only be added in if not included in Total Days. Labor & Delivery days should never be included twice for the allowable DSH percentage calculation because doing so artificially dilutes the Provider's DSH percentage. The Provider therefore contends that the MAC erred by allowing the days in question to be counted twice for the purposes of the DSH adjustment.

On May 29, 2018, the Medicare Contractor filed a Jurisdictional Challenge over these two issues.[5]

Medicare Contractor's Jurisdictional Challenges & the Provider Reponses:

A. Issue 9 – Pharmacy Residency Program

With regard to the Pharmacy Residency Program issue, the Medicare Contractor argues that the Provider has appealed this issue even though no adjustment was made to tis Pharmacy Resident Program. It states that it accepted the as-filed numbers for the final cost report. The Provider has cited audit adjustments 1 through 5 in its initial appeal, but none relate to the Pharmacy Residency Program issue. In its Preliminary Position Paper the Provider cited its audit adjustment which removed a protested amount, but this did not include an amount related to the Pharmacy Residency Program.

In response, the Provider notes that for ten years prior to the current appealed FY, it claimed the Pharmacy Residency Program costs as a pass through reimbursable cost. Each year, the Medicare Contractor adjusted the costs stating they did not qualify as approved nursing and allied health education program pass-through costs. As a result, for the FY under appeal, the Provider determined it would be futile to continue to claim the costs as pass-through costs and reported them as Pharmacy general service costs as directed by the Medicare Contractor. Indeed, the Provider explained this position to the Medicare Contractor in a transmittal letter accompanying the submission of its cost report.[6] The Medicare Contractor has conceded the Provider's past practice in its jurisdictional challenge.[7] The Provider argues that it has essentially self-disallowed the costs, and that CMS Ruling 1727-R requires the Board to reject the Medicare Contractor's "no dissatisfaction" arguments.[8]

B. Issue 10 – Calculation of the Medicaid Fraction not to include Labor Room Days twice in the denominator

Similarly, with regard to the L&D Days issue, the Medicare Contractor claims that the Provider did not identify an audit adjustment related to the issue, but noted "cost report flow." It notes that none of the Provider's Total Patient Days, or specifically Total Labor Room Days, were adjusted, and that the Medicare Contractor accepted the as-filed numbers for the final cost report.

In response, the Provider notes that its DSH percentage was adjusted, and that this is sufficient to preserve its appeal right on this issue.[9] The Provider also concedes, however, that it made an error "stemm[ing] from an ambiguity on and/or a misunderstanding of the cost report form,

[5] The challenge also covered Issue 5, but the Provider withdrew the issue in its response to the challenge.
[6] Providers' Response to Medicare Administrative Contractor's Jurisdictional Challenge at 3-4 (June 22, 2018) (citing Ex. P-34).
[7] *Id.* at 4 (citing Medicare Contractor's Jurisdictional Challenge at 8).
[8] *Id.* at 4-16.
[9] *Id.* at 24.

itself."[10] This error ultimately resulted in the double-counting of the Provider's labor and delivery days and, as such, the Medicare Contractor incorrectly determined the Provider's DSH Medicaid Fraction and ultimate DSH percentage. It claims that the Medicare Contractor has a legal obligation to audit completely and correctly and this error should have been obvious to the Medicare Contractor.[11]

The Provider also argues that the Board is *obligated* to correct this specific error pursuant to 42 U.S.C. § 1395oo(d) – that the revisory power over issues not presented by a hospital to its Medicare Contractor is ***not*** discretionary but compulsory.[12]

Decision of the Board

A Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [13] and
- The amount in controversy is $10,000 or more.[14]

A. Jurisdiction – 1727-R

For purposes of Board jurisdiction over a Provider's appeal for cost report periods ending prior to December 31, 2008 the Provider may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the appealed issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[15] 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.[16]

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[10] *Id.* at 17.
[11] *Id.* at 21, 23 (citing CMS Pub. 100-6, Chapter 8, Section 30.2 (copy at Exhibit P-53)) and 42 C.F.R. § 421.100.
[12] *Id.* at 26 (citing *Bethesda*, 485 U.S. at 406).
[13] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[14] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[15] 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.).
[16] *Bethesda at 1258-59.*

On August 21, 2008, new regulations governing the Board were effective.[17] 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*").[18] 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.[19]

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

The Board has determined that the Pharmacy Residency Program issue appealed by the Provider in this case is governed by CMS Ruling CMS-1727-R. Based on the Medicare Contractor's disallowance of these costs for ten (10) years prior to the cost report at issue, the Board finds that it would have been futile for the Provider to continue to claim these costs. As such, the Board finds that the Provider's Pharmacy Residency Program issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." [20]

With regard to the L&D Days issue, however, the Board finds that it does not have jurisdiction over the issue. The Provider concedes that its dissatisfaction was the result of its own error "stemm[ing] from an ambiguity on and/or a misunderstanding of the cost report form, itself."[21] There was no regulation or other payment policy that prevented the Medicare Contractor from making payment in the manner now sought by the Provider as there was nothing preventing the Provider from properly reporting the L&D Days at issue. Specifically, had the Provider had followed the cost report instructions and properly reported and claimed L&D Days, it would have been reimbursed as sought through this appeal In the regard, the cost report instructions in effect for FY 2012 are clear that Labor Room and Delivery Days are ***not*** to be included in Line

[17] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[18] 201 F. Supp. 3d 131 (D.D.C. 2016)
[19] *Banner* at 142.
[20] CMS Ruling 1727 at unnumbered page 6.
[21] *Id.* at 17.

14 of Worksheet S-3.[22] As such, the Board finds that it does not have jurisdiction over this issue and dismisses it from the case.

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

Board Members:

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

For the Board:

1/4/2022

X Clayton J. Nix

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

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

[22] PRM 15-2 § 4005.1 (Rev. 3, Oct. 2012) (stating "Line 14—Enter the sum of lines 7 - 13 for columns 2 - 8, and for columns 12 - 15, enter the amount from line 1. For columns 9 - 11, enter the total for each from your records. *Labor and delivery days* (as defined in the instructions for line 32 of Worksheet S-3, Part I) *must **not** be included on this line*." (bold and italics emphasis added); and, in contrast, stating "Line 32— Indicate in column 7 the count of labor/delivery days for Title XIX and in column 8 the total count of labor/delivery days for the entire facility. . . .").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Determination***
Alta Bates Medical Center (Prov. No. 05-0305)
FYE 12/31/2002
Case No. 16-0565

Dear Mr. Knight and Ms. Frewert:

The above-captioned individual case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2002. The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation in response to a jurisdictional challenge filed by the MAC. Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") related issue and dismisses the instant appeal.

Pertinent Facts

On January 11, 2016, the Board issued a decision granting Sutter Health 2002 Disproportionate Share Hospital ("DSH"') Dual Eligible Days Common Issue Related Provider ("CIRP") Group's ("Sutter Health's") request for bifurcation of issues in Case No. 08-2620GC. The Board granted Sutter Health's request for case bifurcation of the dual eligible Part A non-covered and Part C days issues for all but two providers within the appeal. In addition, the Board created a separate appeal for Alta Bates Medical Center's appeal of the LIP dual eligible days fraction issue, which is the only issue pending in the present appeal.[1]

In this letter, the Board noted that, within its February 4, 2010 request for hearing, the Provider entitled its dual eligible days issue as "Medicare [DSH] Payments/Low Income Payments (LIP)-Dual Eligible Days.'" The Provider went on to explain its dissatisfaction with the way that the Medicare contractor treated its dual eligible days in both the DSH and the LIP calculations for its fiscal year end December 31, 2002 cost report.[2]

[1] Board's Bifurcation Request and Jurisdictional Determination (Jan. 11, 2016), PRRB Case No. 08-2620GC.
[2] *Id*. at 3.

The Board considered issues pertaining to the LIP calculation as separate from issues pertaining to the DSH calculation. As such, the Board bifurcated the Provider's LIP dual eligible days issue from the CIRP group appeal, Case No. 08-2620GC, and established the newly formed Case No. 16-0565, which is currently before the Board.[3]

Board's Analysis and Decision

Applicable Regulatory Provisions and Board Rules

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

Rehab Days in LIP Adjustment Calculations

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*") answers this question and clarifies what is shielded from review in its analysis of this issue.[4]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year."[5] One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the D.C. District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the

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

establishment of the hospital's prospective payment rates.[6] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[7]

In the instant appeal, the Provider seeks Board review of a number of the components utilized by the Medicare Contractor to determine the Provider's LIP adjustment. Because, pursuant to 42 U.S.C. § 1395ww(j)(8)(B), Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeal that challenges this adjustment. In making this finding, the Board relied on the *Mercy* decision and notes that the D.C. Circuit's decision in *Mercy* is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(j)(8)(B) because the Provider could bring suit in the D.C. Circuit.[8] Accordingly, the Board hereby closes the appeal, Case No. 16-0565, and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

1/5/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Truman Medical Center CY 2017 DSH SSI Dual Eligible Days Group
Case No. 20-1901GC

Dear Ms. Griffin:

On July 22, 2021, the Provider Reimbursement Review Board ("Board") issued a Scheduling Order for the setting deadlines for the filing of any substantive claim challenges made pursuant to 42 C.F.R. § 405.1873(a) in the above-referenced appeal. The parties filed responses on August 20, 2021 and September 29, 2021. In reviewing the submissions, the Board identified a discrepancy in the parties' documentation submitted to support their positions with respect to the substantive claim issue for Truman Medical Center Lakewood (provider no. 26-0102) ("Truman Lakewood"). In correspondence dated October 27, 2021, the Board sought an explanation from the parties as to the difference in Provider Exhibit P-2 and Medicare Administrative Contractor ("MAC") Exhibit C-2. The parties' responses were received on November 22, 2021 and December 7, 2021. The decision of the Board with respect to the substantive claim matter and EJR is set forth below.

Issue for which EJR is Requested:

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

> The days at issue in these appeals are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in these appeals is whether the Intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction" for purposes of calculating the Provider's [Disproportionate Share Hospital ("DSH")] payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction CMS is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish Providers with a listing of those SSI*

> *Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[1]

Regulatory Background:

A. Medicare Disproportionate Share Hospital (DSH) Payment Background

The Medicare program pays inpatient hospital services based on predetermined, standardized amounts subject to certain payment adjustments under Medicare's inpatient prospective payment system ("IPPS").[2] One of these adjustments, the Medicare DSH adjustment, provides additional payments to certain qualifying hospitals that treat a disproportionate share of low income patients.[3] The Medicare DSH adjustment is calculated using two fractions known as the Medicare fraction (also referred to as the SSI fraction or SSI ratio) and the Medicaid fraction. Pursuant to 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I), the Medicare fraction is calculated by using: (a) in the numerator, the "number of such hospital's patient days…which were made up of patients who (for such days) were ***entitled*** to benefits under part A of the subchapter and were ***entitled*** to supplementary security income benefits…under subchapter XVI of this chapter…";[4] and (b) in the denominator, the number of days of care that are furnished to patients who were entitled to Medicare Part A. The Secretary[5] incorporated this statutory provision into the regulations at 42 C.F.R. § 412.106(b)(2)(i)(B) which states:

> (2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –

[1] EJR Request at 2-3 (emphasis added).
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)
[5] of the Department of Health and Human Services.

> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

The dispute in these appeals involves CMS' determination of which patients are "entitled to" both Medicare Part A and SSI benefits for purposes of the Medicare fraction of the DSH calculation.

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[7] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[8] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[9]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[10] In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[11]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic

[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).
[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.

redeterminations to ensure continued eligibility[12] and may terminate,[13] suspend[14] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[15] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]
4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[21]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its

[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).

website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[27]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[28] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[29] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[30]

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[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.

[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

[30] *Id.* at 5-6.

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[31] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[32]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.

adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2111 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[41]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

B. Background on the Appropriate Cost Report Claim Requirement at 42 C.F.R. §§ 413.24(j) and 405.1873

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[43] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[44] The Secretary revised the Medicare cost reporting regulations in 42 CFR part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the MAC or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board. The changes also specified the procedures for Board review of whether a provider's cost report meets the proposed substantive reimbursement requirement of an appropriate cost report claim for a specific item.[45]

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[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[43] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[44] *Id.* at *70555.*
[45] *Id.* at 70551.

1. Background for Payments and Cost Reporting Requirements

For cost reporting years beginning before October 1, 1983, all providers were reimbursed on a reasonable cost basis for Medicare Part A (hospital insurance) covered items and services that were furnished to Medicare beneficiaries. Reasonable cost is defined at 42 U.S.C. § 1395x(v)(1)(A) and implementing regulations at 42 C.F.R. Part 413. In the Social Security Amendments of 1983 (Pub. L. 98–21), Congress added 42 U.S.C. § 1395ww(d) to the statute, which, effective with cost reporting periods beginning on or after October 1, 1983, changed the payment method for inpatient hospital services furnished by short-term acute care hospitals to an inpatient prospective payment system ("IPPS"). In accordance with § 1395ww(d) and implementing regulations at 42 C.F.R. Part 412, an IPPS payment is made at a predetermined specific rate for each hospital discharge (classified according to a list of diagnosis-related groups ("DRGs")), excluding certain costs that are paid on a reasonable cost basis.[46]

Under IPPS, providers are generally paid for each patient discharge after a bill is submitted. The statute, 42 US.C. §§ 1395g(a) and 1395l(e), provide that no payments will be made to a provider unless it has furnished the information, requested by the Secretary needed to determine the amount of payments due the provider under the Medicare program. In general providers submit this information through annual cost reports that cover a 12-month period of time. All providers participating in the Medicare program are required under 42 C.F.R. § 413.20(a) to maintain sufficient financial records and statistical data for proper determination of costs. Moreover, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the hospital and related fields. Under the provisions of 42 C.F.R. §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year.[47]

2. History on Appropriate Claims and the Promulgation of 42 C.F.R. §§ 412.24(j) and 405.1873

Until 1988, when the Supreme Court issued its decision in *Bethesda Hospital v. Bowen* ("*Bethesda*"),[48] the Secretary did not allow providers to "self-disallow" a claim for reimbursement. A self-disallowance occurs were the provider submits a cost report that complies with Medicare policy for an item and then appeals an item to the Board that was ***not*** *included in its cost report.* In this situations, the MAC's NPR does not include a disallowance or adjusgment for that item. In *Bethesda*, the U.S. Supreme Court held that despite the providers failure to claim all of the reimbursement they believed should have been made, the plain language of the dissatisfaction requirement in 42 U.S.C. § 1395oo(a)(1)(A) supported Board jurisdiction because the MAC had no authority to award reimbursement in excess of a regulation by which it was bound. Consequently, it would have been futile for the providers to try to persuade the MAC otherwise. The U.S. Supreme Court also stated in *dicta*, that the dissatisfaction requirement might ***not*** be met if providers were to ''bypass a clearly prescribed

[46] *Id.* at 70552.
[47] *Id.* at 70552-3.
[48] 485 U.S. 399 (1988).

exhaustion requirement or . . . fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules''[49, 50]

In light of the U.S. Supreme Court's decision in *Bethesda*, the Secretary addressed the dissatisfaction requirement when it updated the Board's regulations in 2008[51] by revising 42 C.F.R. § 405.1835(a)(1).[52] Under the revised regulations, the Secretary required that in order to preserve its appeal rights, a provider must either claim an item in its cost report where it is seeking reimbursement that it believes to be in accordance with Medicare policy, or self-disallow the item if it is seeking reimbursement that it believes may not comport with Medicare policy (for example, where the contractor does not have the discretion to award the reimbursement sought by the provider). In order to self-disallow an item, the provider was required to follow the applicable procedures for filing a cost report under protest, which are contained in § 115 of the Provider Reimbursement Manual, CMS Pub. Part 2 ("PRM 15-2").[53]

Subsequently, in 2015, this regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[54] 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 U.S. District Court for D.C. 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.[55]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals:

> CMS continues to believe that the self-disallowance regulation, 42 CFR 405.1835(a)(1)(ii), is a reasonable interpretation of the dissatisfaction requirement for PRRB jurisdiction in section 1878(a)(1)(A) of the Act (42 U.S.C. 1395oo(a)(1)(A)). Nonetheless, we did not appeal the *Banner* decision, and any provider may file lawsuits in the U.S. District Court for the District of Columbia. Accordingly, CMS has decided to apply the holding of the district court's *Banner* decision to certain similar administrative appeals.[56]

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, "[i]f

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[49] *Id.* at 404-405.
[50] 80 Fed. Reg. at 70554.
[51] *See generally,* 73 Fed. Reg. 30190 (May 23, 2008). (Provider Reimbursement and Appeals Final Rule).
[52] *Id. at* 30195-30200.
[53] 80 Fed. Reg. at 70557.
[54] 201 F. Supp. 3d 131 (D.D.C. 2016).
[55] *Id.* at 142.
[56] CMS Ruling 1727-R at 5.

the PRRB . . . determines that the specific item under appeal was subject to a regulation or other payment policy that bound the Medicare contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, then the pertinent reviewing entity shall not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable), to the specific non-allowable item under appeal; instead, the reviewing entity should apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures."[57]

Prior to CMS Ruling 1727-R and concurrent, with the *Banner* litigation, the Secretary promulgated new cost reportinging regulations. Specifically, as part of the November 13, 2015 Final Outpatient Prospective Payment Rule,[58] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim effective for cost reporting period beginning on or after Jauary 1, 2016.[59] The Secretary determined that the requirement that a provider either claim reimbursement for a specific cost, or expressly self-disallow the cost, in its cost report is more appropriately treated as a cost reporting requirement under 42 U.S.C. §§ 1395g and 1395l, as the Secretary cannot make payments to a provider without sufficient information on all claims for which the provider believes it should be paid.[60] To that end, the Secretary added a new paragraph (j) to 42 C.F.R. § 413.24. Paragraph (j)(1) of § 413.24 provides that, in order to receive or potentially qualify for payment for a specific item, the provider must include *on its cost report* an appropriate claim for the specific item. *In order to make an appropriate claim for an item* ***on its cost report***, the provider must either claim payment for the item in its cost report where it is seeking payment that it believes is consistent with Medicare policy, or self-disallow the item on the cost report if the provider is seeking payment that it believes may not comport with Medicare policy (for example, where the MAC does not have the authority or discretion to award the payment sought by the provider). In order to properly self-disallow a specific item on the cost report, the provider would have to follow the applicable procedures for filing a cost report under protest.[61]

Specifically, for cost report periods beginning on or after January 1, 2016,[62] the regulations at 42 C.F.R. §§ 413.24(j) specifies:

> (1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—

[57] *Id*. at 7.
[58] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[59] These regulations were effective for cost reporting periods beginning on or after January 1, 2016 (See 80 Fed. Reg. 70298).
[60] *Id*. at 70554.
[61] *Id*. at 70555.
[62] *Id*. at 70298.

> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .

> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[63]

These regulations are applicable to the cost reporting period under appeal in this case.

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that

[63] (Bold and underline emphasis added.)

this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[64]

The Providers note that, in administering the SSI program, SSA assigns each beneficiary a Patient Status Code ("PSC"). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the FY 2011 IPPS Final Rule that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[65] Thus, the Providers allege the exclusion of the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[66]

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. Jurisdiction

The Medicare Contractor filed a jurisdictional challenge on August 3, 2021 contending that the participants in Case No. 20-1901GC are also participants in the optional group appeal under Case No. 19-2600G (Hall Render CY 2017 DSH SSI Post 1498R Data Match Group), and that both cases contain the same issue. The Provider maintains that the groups are not duplicative. The Board finds that the other optional group case cited above (*i.e.*, Case No. 19-2600G) is ***not*** duplicative, but rather deal with a different issue.[67] The SSI data match issue as presented in

[64] 75 Fed. Reg. at 50275-86.
[65] *Id.* at 50281.
[66] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[67] The Board notes that 42 C.F.R. § 405.1837(b) specifies that there may be only one common issue per group appeal. To the extent, the Providers in Case No. 19-2600G maintain that the group appeal contains ***another*** issue *in addition to the SSI data match issue* (*e.g.*, the SSI entitlement/eligible days issue in the instant appeals), then the Board will review the claim and, to the extent it agrees, will address the prohibited additional issue as part of Case

Case No. 19-2600G is a technical issue which alleges that, notwithstanding the revisions CMS made to its data match process following *Baystate*, there are *still* systematic errors that exist with CMS' revised data matching process and, therefore, it does not properly capture all SSI eligible individuals that should be captured when the revised data matching process as defined by CMS is applied and carried out. In contrast, in Case No. 20-1901GC, the Providers dispute CMS's interpretation of the statutory phrase "entitled to [SSI] benefits"[68] and maintains that it should be more broadly interpreted so that additional SSI days are captured in the numerator of the Medicare fraction (*e.g.*, the Providers maintain days where the patient may only be receiving an SSI medical benefit but no cash SSI benefits should be included in the DSH Medicare numerator). Accordingly, the Board finds that these are not duplicative cases.

The participants that comprise the group appeal within this EJR determination, have filed appeals involving fiscal year 2017. Based on its review of the record, the Board finds that each of the participants in this case filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

B. Appropriate Cost Report Claim – Findings of Fact and Conclusions of Law

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[69] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

On July 22, 2021, the Board sent the parties a letter noting that in the case referenced above, one or more of the participants had cost reporting perioding beginning on or after January 1, 2017, and as a result the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. The MAC filed a Substantive Claim Challenge for both participants in thie CIRP group and the Providers responded to this challenge. Neither party requested that the Board conduct an oral proceeding on the substantive claims challenges.[70] In addition, the Board on October 27, 2017, the Board sent the parties a letter asking them for additional information relative to one of the participants, namely to explain the differences in Provider Exibit P-2 and MAC Exhibit C-2 for Truman Lakewood (Prov. No. 26-0102) to which the parties responded on November 22 and December 7, 2021.

No. 18-1465G and take remedial action such as dismissal of any such prohibited additional and/or duplicative issue, as appropriate.

[68] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

[69] (Emphasis added.)

[70] In its July 22, 2021 request for information, the Board advised the parties: "If a party desires to have additional evidence or argument considered (e.g., testimony or oral argument), that party must submit a request to the Board with both a description of and an explanation of the need for such additional evidence/argument (whether written or oral). Otherwise, following the above referenced filing deadline, the Board will proceed with issuing a ruling on § 413.24(j) compliance issue(s) based solely on the record before it."

1. MAC's Substantive Claim Challenge

The MAC asserts that both participants in this CIRP group failed to include an appropriate cost report claim for dual eligible days on their as-filed cost report in accordance with 42 C.F.R. § 413.24(j).

a. Truman Medical Center Lakewood (Prov. No. 26-0102) ("Lakewood")

The MAC contends that there is nothing in the record to show where Lakewood attempted to claim the disputed item for full reimbursement based on Lakewood's belief that the items did comported with Medicare policy. Lakewood identified Adjustment 29 and 30, as the basis for their appeal. These adjustments adjusted Lakewood's DSH SSI ratio and the DSH percentage. The MAC states that these adjustments are not germane to the issue under dispute and do not indicate that Lakewood sought to claim the full amount of reimbursement for the specific item in dispute.

Further, the MAC notes that Lakewood submitted a cost report claiming $161,685 of Part A protested amounts on Worksheet E, Part A, Line 75. However, Lakewood did not attach a separate worksheet to the cost report for each specific self-disallowed item or explaining why the cost were disallowed. In addition, when the appeal was filed the Representative did not enter the appeal in OH CDMS indicating their appeal was filed under protest for the issue under dispute. Thus, Lakewood did not self-disallow the item under protest as described at 42 C.F.R. § 413.24(j). Based on the information above, the MAC asserts that Lakewood's failed to self-disallow the dual eligible issue as prescribed in 42 C.F.R § 413.24(j).

In response to the Board RFI related to the conflicting exhibits, the MAC's position is that MAC Exhibit C-2 at pages 1-2 accurately represents the protested items summary submitted with Lakewood's as-filed cost report. The MAC contends that MAC Exhibit C-2 demonstrates that the documents do not include an explanation for "why the Provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the Provider calculated the estimated reimbursement amount for each specific self-disallowed item" as required by 42 C.F.R. § 413.2(j)(2)(i).

Subsequently, on May 24 , 2019, Lakewood submitted a second amended cost report (the first one was rejected) but did not amend its protest amount or submit any documents related to protest amounts. As a result of the desk review, Lakewood submitted additional protest amount documents which were received by the MAC for the first time on or around October 7, 2019. These additional documents are reflected in Exhibit P-2. However, the MAC asserts that the requirements of § 413.2(j) were still not met as these documents were not included with either Lakewood's as-filed cost report or Lakewood's as-filed second amended cost report.

b. Truman Medical Center Hospital Hill (Prov. No. 26-0048) ("Hospital Hill")

The MAC again asserts that there is no evidence in the record to show that Hospital Hill attempted to claim the disputed item for full reimbursement based on Hospital Hill's belief that the costs comport with Medicare policy. In its original hearing request, Hospital Hill just appealed adjustment 20, which adjusted Hospital Hill's DSH SSI ratio and DSH percentage. There was no adjustment to dual eligible days. Once again, Hospital Hill submitted protested amounts on Worksheet E, Part A, Line 75 but did not attach a separate sheet explaining why the costs were self-disallowed or how the estimated amount in controversy was calculated. As above, Hospital Hill did not include adjustment 25 in its original hearing request. On May 24, 2019, Hospital Hill submitted a second amended cost report (the first amended cost report was rejected) but did not amend its protested amount or submit any documents related to protested amounts. As part of the cost report desk review, Hospital Hill submitted additional protested amount documents which were received and accepted by the MAC for the first time on or about October 7, 2019. The additional documents were reflected in Provider's Exhibit P-2, but, the MAC points out, were not included with the Provider's as-filed cost report. As a result, the MAC maintains that the documents in MAC Exhibit C-2 accurately reflect Hospital Hill's only supporting documents for protested amounts submitted with the as-filed cost report.

In response to the Board request for clarification, the MAC clarifies that Hospital Hill submitted only two pages summarizing the items under protest with its as-filed cost report. Along with its cost report, Hospital Hill submitted hard copies of its supporting documents which MAC scanned and saved as a PDF file exceeding 1,000 pages in length. The MAC included the relevant pages (along with the immediately preceding and following pages) related to as-filed protested amounts as MAC Ex. C-7. The MAC clarifies that in MAC Ex. C-3, pages 3-8 were not included in Hospital Hill's supporting documentation submitted with its as-filed cost report. Hospital Hill also submitted a second amended cost report on May 24, 2019, in which it did not amend its protested amounts. Hospital Hill submitted additional documents related to protest amounts amounts at the time of the desk review which were received by the MAC on or about October 7, 2019. The MAC asserts that the documents in MAC Ex. C-7, at pages 2-3, accurately reflect Hill only supporting documentation for protested amounts submitted with its as-filed cost report and do not include an explanation for "why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how it calculated the reimbursement effect for each specific item as required by 42 C.F.R. § 413.25(j)(2)(ii).

The MAC notes that Hospital Hill did not submitted any evidence demonstrating that supporting documents related to protested amounts beyond those in MAC Exhibits C-6 and C-7 were attached to its as-filed or second amended cost reports. The MAC believes this demonstrates that Hosptial Hill failed to properly self-disallow the item on appeal in this case.

2. Providers' Position: Substantive Claim Challenge

The Providers believe that both Truman Medical Center Hill and Truman Medical Center Lakewood have claimed dual eligible days as a protested item on their respective cost reports.

The Providers maintain that Provider Ex. P-1 contains a narrative and a calculation for the dual eligible days issue and they maintain that the calculations for the dual eligible days issue cannot be determined by the Provider since the Social Security Administration and CMS bar providers' access to that information.

The Providers content that the regulations does not require providers also expressly self-disallow supplemental payment sought for the same items under a purely legal challenge beyond the MAC's authority to address. Rather, it only requires that an appropriate claim for the specific item be included by either claiming full reimbursement in accordance with Medicare policy or self-disallow the item. Where some reimbursement is available it is nonsensical to require that a provider self-disallow the item foregoing available reimbursement in favor of seeking greater reimbursement through appeal.

a. Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

The Providers go on to assert that the MAC has issued a substantial claim letter indicating that the Providers are subject to the "substantial claim" requirements of 42 C.F.R. §§ 413.24(j) and 405.1873, effective with cost reporting periods beginning on or after January 1, 2016. However, the Providers note that the MAC that prior to the January 1, 2016 period, a nearly identical regulatory policies were stricken by the Federal courts in *Bethesda Hospital Association v. Bowen*[71] (*"Bethesda*") and *Banner Heart Hospital v. Burwell ("Banner").*[72] The Providers believe that, pursuant to 42 U.S.C. § 1395oo(a), they only need to be dissatisfied with the final determination of the MAC and meet the monetary threshold for Board jurisdiction.

The Providers note that in *Bethesda* the Supreme Court noted that where a cost report is filed in full compliance with the Secretary's rules and regulations, does not, by itself, bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. This is particularly true where providers know that a MAC is limited to the mere application of the regulations and that any attempt to persuade the intermediary to do otherwise would be futile. The submission of a regulatory challenge was deemed unnecessary and was distinguished from providers who bypass clearly prescribed exhaustion requirements.

When enacting the 2008 update to the Board's regulations, 42 C.F.R. § 405.1835(a)(1), the Secretary instituted the requirement that in order to preserve their appeal rights, providers must either claim a cost on their cost reports or file the matter under protest. In reviewing this requirement the Court in *Banner* when examining a challenge to the validity of a regulation, the Court noted that satisfaction with a regulatory scheme cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the MAC. The Court found that submitting a regulatory challenges to the MAC was unnecessary and conflicted with the plain meaning of 42 U.S.C. § 1395oo. Subsequently, the Administrator[73] implemented CMS Ruling CMS-1727-R eliminating the regulatory self-disallowance requirements prior to January 1, 2016.

[71] 485 U.S. 399, 400 (1988).
[72] 201 F.Supp. 3d 131, 133 (D.D.C. 2016).
[73] of the Centers for Medicare & Medicaid Services.

Here, the Providers assert, the Board should disregard the 2016 regulation requiring administrative exhaustion (filing a cost report under protest) a prerequisite to payment. The Providers maintain where the issue under appeal is a regulatory challenge, the exhaustion requirement outlined in 42 C.F.R. §§ 413.24(j) and 405.1873 denies providers meaningful review, even if it does not bar jurisdiction. Further, the 2016 regulations violates the Providers statutory right to appeal under 42 U.S.C. § 1395oo(a) because a procedural finding that that payment for the Providers' claims was foreclosed voids the Board's jurisdiction.

b. Conflicting Exhibits

In response to the Board's inquiry regarding the discrepancies in the exhibits in the substantive claim responses, the Group Representative asserts that Provider Ex. P-5 accurately represents the entire Protest Document package submitted with Truman Lakewood's as-filed cost report. The Provider contends that Provider Exhibits P-5 and P-2 include an explantion for "why the provider self-disallowed each specific item (instead of claiming full reimbursement on its cost report for the specific item) and describe[ing] how the provider caculated the estimiated reimbursement amount for each specific self-disallowed item" as required by 42 C.F.R. § 413.24(j)(2)(ii).

The Group Representative also notes that the MAC's auditor requested supporting documentation from Lakewood prior to beginning the audit, including Lakewood's protested item support. This information was furnished and the Auditor made an adjustment to remove the total protested amount included in the cost report. Lakewood submitted an affidavit stating that the Provider had complied with 42 C.F.R. § 413.24(j)(2). In addition, the cost report preparer attested to preparing the cost report and including all cost report workpspers, including protested amount workpapers that were submitted with the cost report. The Group Representative believes Lakewood as fulfilled the substantive claim requirements.

The Group Representative presented the exact same factual scenario for Hospital Hill.

3. Board Analysis on Provider Compliance with the Appropriate Cost Report Claim Requirements

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[74] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

At the outset, the Board recognizes that the Group Representative has raised arguments challenging the *substantive* validity of 42 C.F.R. §§ 413.24(j) and 405.1873 and that, as the Board is otherwise bound

[74] (Emphasis added.)

by these regulations, it does not have the authority to decide those legal questions. However, those arguments are made ***in the alternative***. For both participants, the Group Representative *first* argues that, contrary to the Medicare Contractor's assertion, they actually met the requirements of these regulations. Accordingly, EJR of these in-the-alternative arguments is *not* appropriate because the Board must resolve and issue a decision on the factual dispute between the parties on whether those requirements were met. The Board notes that review of the Board's factual and legal findings regarding that dispute may be available pursuant to 42 C.F.R. §§ 405.1842(g) and 405.1875(a)(2)(v) and that such review necessarily would encompass the Group Representative's in-the-alternative arguments regarding the substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[75] Accordingly, the Board has set forth below its factual and legal findings on that question regarding these two participants.

In this case, both participants have established that they had filed the issue that is the subject of this appeal under protest. Initially, the record before the Board did not establish that either Provider submitted the requisite *supporting* workpapers with their as-filed costs (or amended cost report, as relevant). In this regard, contrary to the Group Representative's assertion, the affidavit does ***not*** state that the complete set of documents at Provider Ex. P-5 was submitted with the as-filed cost report. Indeed, as shown in Provider Ex. P-9, the MAC emailed the Providers during the audit because it had not received the supporting workpapers and specifically requested that the Providers submit those documents. The Providers then supplied the requested supporting workpapers and the MAC accepted the supporting documents. Because the MAC requested and accepted those supporting workpapers during the audit phase, they became part of the relevant as-filed cost reports and the Providers, in essence, cured the initial filing defect. The Board's review of those supporting workpapers confirm that they complied with the requirement in 42 C.F.R. § 413.23(j)(2)(ii) that they "explain[] why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describe[e] how the provider calculated the estimated reimbursement amount for each specific self-disallowed item." Accordingly, the Board finds that Truman Hospital Medical Center Hill (Prov. No. 26-0058, FYE 6/30/17) and Truman Center Lakewood (Prov. No. 26-0102, FYE 6/30/17) complied with their obligation under § 413.424(j)(1) to "include an appropriate claim for the ***specific*** item"[76] by either: (1) "[c]laiming ***full*** reimbursement . . . for the specific item"[77]

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[75] Note that Administrator review under 42 C.F.R. § 405.1875(a)(2)(v) is referenced in § 405.1842(g). *See also* 42 C.F.R. § 405.1873(f)(2).

[76] The Board notes that "specific item" is the same language used in following excerpt from 42 C.F.R. § 405.1835(b) entitled "Contents of request for a Board hearing on final contractor determination": "The provider's request for a Board hearing under paragraph (a) of this section must be submitted in writing in the manner prescribed by the Board, and the request must include the elements described in paragraphs (b)(1) through (4) of this section. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (2), or (3) of this section, the Board may dismiss with prejudice the appeal or take any other remedial action it considers appropriate. . . . (2) For each ***specific item*** under appeal, a separate explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the final contractor or Secretary determination under appeal, including an account of all of the following: (i) Why the provider believes Medicare payment is incorrect for each disputed item (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment). (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item. (iii) *If the provider self-disallows a* ***specific item*** *(as specified in § 413.24(j) of this chapter), an explanation of the nature and amount of each self-disallowed item, the reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.*" (Empahsis added.)

[77] (Emphasis added.)

(*i.e.*, claiming the ***full*** reimbursement it believes it is due as a result of the alleged error in the SSI fraction as used in the DSH adjustment calculation); or (2) protesting the issue in this appeal following the procedures set forth in § 413.424(j)(2) "for properly disallowing the specific item in the provider's cost report as a protested amount."

C. *Board Determination on the Providers' EJR Request Filed June 23, 2021*

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[78] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[79]

Contemporaneous with CMS Ruling 1498-R[80] the Secretary published a proposed IPPS rule[81] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[82]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the

[78] CMS Ruling 1498-R at 27.
[79] *Id.* at 31.
[80] *Id.* at 5.
[81] 75 Fed. Reg. 23852, 24002-07.
[82] 75 Fed. Reg. at 50277.

> MedPAR file that we are not able to locate in the EDB[83] which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[84]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[85] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound by the Uncodified SSI Data Match Regulation published in the FY 2011 Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified SSI Data Match Regulation which they allege fails to include all of the PSC codes used by SSA to determine SSI eligibility. As a result, the Board finds that EJR is appropriate for the issue for the calendar year under appeal in this CIRP group appeal.

D. Summary of the Board's Findings:

The Board makes the following findings:

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

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[83] (Medicare) Enrollment Database.
[84] 75 Fed. Reg. at 50285.
[85] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

2) Both participants complied with and met the substantive reimbursement requirement of an appropriate cost report claimin 42 C.F.R. §§413.24(j) for the subject issue;

3) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

4) It is without authority to decide the legal question of whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) 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, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

1/6/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal***
Galesburg Cottage Hospital (Prov. No. 14-0040)
FYE 4/30/2013
PRRB Case No. 16-1015

In connection with the above captioned case, the Provider Reimbursement Review Board ("Board") has reviewed Galesburg Cottage Hospital's ("Provider") appeal following the Board's Notice of Non-Compliance with Mandatory Electronic Filing Requirement ("Notice") issued on December 14, 2021. The Board's Notice was sent with regard to your compliance with the mandatory electronic filing requirement that went into effect November 1, 2021.[1]

On June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement:

> Effective November 1, 2021, ***all*** *submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) ***must*** *be filed electronically* using the Office of Hearings Case and Document Management System ("OH CDMS"), unless the Board grants an exemption.[2]

Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1.[3] As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties' designated representatives.

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[1] The Board's authority to mandate electronic filing is based the Final Rule published on September 18, 2020, 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020) as incorporated into the regulations at 42 C.F.R. § 405.1801(d).
[2] Board Order No. 1 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (emphasis added). Board Alert 21 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts. *See also* Board Rule 2.1.1 (Nov. 1, 2021) (stating in part: "Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").
[3] On September 30, 2021, the Board issued Board Order No. 2 to publish additional revisions to the Board Rule in order to further clarify the revisions published on June 16, 2021. However, these revisions did not impact Board Rule 2.1. *See also* Board Alert 22.

The Board's Notice informed you that it received a hard copy filing for a position paper for the above-captioned case on November 1, 2021 that did not comply with the mandatory electronic filing requirement.[4] The Board recognized that Board Alert 19 which suspended Board-set deadlines remains in effect and that the position paper was mailed for filing *prior to* November 1, 2021. However, whenever a filing is made, *it **must** comply with Board Rules*. ***Accordingly, the Board's Notice specifically stated that we will not accept your filing in hard copy format as it failed to comply with Board Rule 2.1.1***. As a result, the hard copy filing was ***not*** made part of the record for the above-captioned case.

Notwithstanding, **as a one-time courtesy**, the Board permitted you to cure the defect by filing the position paper electronically using OH CDMS ***within five (5) business days of the Notice's signature date (or December 21st, which was 5 business days from the December 14th, 2021 notice)***. The Board further noted that *you are a registered user of OH CDMS, and as such since the Provider was ready to make the filing in question and the representative is a registered user of OH CDMS, the filing deadline was **firm** and the Board specifically **exempted** it from the Board Alert 19 suspension of Board-set deadlines.* Accordingly, the Board stated that failure to meet the filing deadline may result in dismissal or other remedial action.

Board Rule 41.2 (v. 3.1, 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),**
- **if the Board is unable to contact the provider or representative at the last known address**, or
- upon failure to appear for a scheduled hearing.

Further, Board Rule 5.2 addressed the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (*see* Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;

[4] The Board Rules are available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

- Meeting the Board's deadlines; and
- Responding timely to correspondence or requests from the Board or the opposing party.

> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

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

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

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. **In each case, *and as appropriate*, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board**.[5]
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

[5] (Emphasis added.)

Board Decision:

Since no position paper has been timely filed in compliance with Board Rule 2.1.1 or the Board's December 14, 2021 Notice of Noncompliance, the Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case. Indeed, to date, the Provider failed to respond to the Board's December 14, 2021 Notice of Noncompliance. As such, the Board hereby dismisses the case and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

1/6/2022

X Clayton J. Nix

Clayton J. Nix, Esq.
Chair
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cc: Byron Lamprecht, WPS Government Health Administrators
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Via Electronic Delivery

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RE: ***Own Motion EJR***
Case No. 18-0928GC – NYC Health + Hospitals FFY 2018 Understatement of Documentation and Coding Repayment Adjustment CIRP Group
Case No. 20-1137GC – NYCHHC FFY 2020 NYCHHC-Underpayment of Documentation and Coding Repayment CIRP Group
Case No. 21-1104GC – NYCHHC FFY 2021 NYCHHC FFY 2021 Documentation and Coding IPPS Underpayments CIRP Group

Dear Mr. Willey:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced common issue related party ("CIRP") group appeals and, on August 3, 2021, as required by 42 C.F.R. § 405.1842(c), notified the Providers that it was considering, on its own motion, whether Expedited Judicial Review ("EJR") was appropriate.[1] Having received comments from the parties, the decision of the Board is set forth below.

Issue in Dispute

The Providers are challenging CMS' failure to restore an expired 0.7 percent reduction to Medicare IPPS rates for inpatient discharges at all IPPS hospitals, including the Providers, for the FFYs 2018, 2020, and 2021 IPPS Final Rules.[2]

Statutory and Regulatory Background:

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 believes that, by increasing the number of MS–DRGs and more fully taking in to

[1] The Board's Request also notified the parties that the Board was deeming the cases as fully formed and complete pursuant to 42 C.F.R. § 405.1837(e)(1) ("The Board determines that a group appeal . . . is fully formed . . . following an order from the Board that in its judgement, that the group is fully formed . . . .").
[2] Providers Statement of the Group Appeal at 1.
[3] 72 Fed. Reg. 47130, 47140-47189 (Aug. 22, 2007).
[4] of the Department of Health and Human Services.

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. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

On September 29, 2007, Congress enacted the TMA [Transitional Medical Assistance], Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 ("TMA").[7] TMA § 7(a) reduced the documentation and coding adjustment made as a result of the MS–DRG system that the Secretary adopted in the FY 2008 IPPS final rule to -0.6 percent for FY 2008 and -0.9 percent for FY 2009.[8]

The Secretary implemented a series of adjustments required under TMA §§ 7(b)(1)(A) and 7(b)(1)(B) based on a retrospective review of FY 2008 and FY 2009 claims data. The Secretary completed these adjustments in FY 2013. However, the Secretary commented in the FY 2013 IPPS final rule that delaying full implementation of the adjustment required under TMA § 7(b)(1)(A) until FY 2013 had resulted in payments in FY 2010 through FY 2012 being overstated, and that these overpayments could not be recovered.[9]

Congress revisited TMA § 7(b)(1)(B) as part of the American Taxpayer Relief Act of 2012 ("ATRA").[10] Specifically, ATRA § 631 amended TMA § 7(b)(1)(B) to add clause (ii) which required the Secretary to make a recoupment adjustment or adjustments totaling $11 billion for discharges occurring during FYs 2014 to 2017. Per the revisions made by ATRA § 631(b), this adjustment "represents the amount of the increase in aggregate payments from fiscal years 2008 through 2013 for which an adjustment was not previously applied" (*i.e.*, represents the amount of the increase in aggregate payments as a result of not completing the prospective adjustment authorized under TMA § 7(b)(1)(A) until FY 2013).[11] As discussed above, this delay in implementing TMA § 7(b)(1) resulted in overstated payment rates in FYs 2010, 2011, and 2012 and the resulting overpayments could not have been recovered under the original TMA § 7(b).

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[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).
[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.
[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.

The adjustment required under ATRA § 631 was a one-time recoupment of a prior overpayment, not a permanent reduction to payment rates. Therefore, the Secretary "anticipated that any adjustment made to reduce payment rates in one year would eventually be offset by a positive adjustment in FY 2018, once the necessary amount of overpayment was recovered."[12]

However, Congress again stepped in to revise TMA § 7(b)(1)(B). First, in § 414 of the Medicare Access and CHIP Reauthorization Act of 2015 ("MACRA"), Congress revised TMA § 7(b)(1)(B) to add clause (iii) which replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023.[13] Second, in § 15005 of the 21st Century Cures Act ("21-CCA"),[14] Congress amended the MACRA revision in TMA § 7(b)(1)(B)(iii) by reducing the adjustment for FY 2018 from 0.5 percentage points to 0.4588 percentage points.[15]

The Secretary's "actuaries estimated that a -9.3 percentage point adjustment to the standardized amount would be necessary if CMS were to fully recover the $11 billion recoupment required by [ATRA § 631] in FY 2014." Consistent with the policies that the Secretary has adopted in many similar situations, the Secretary implemented a phased in approach. For the first year, FY 2014, he implemented a -0.8 percentage point recoupment adjustment to the standardized amount. The Secretary declined, at that time, to set specific adjustments for FYs 2015, 2016, or 2017 "[a]s estimates of any future adjustments are subject to variations in total savings[.]"[16] However, he did estimate that, if adjustments of -0.8 percentage point were implemented in FYs 2014, 2015, 2016, and 2017, using standard inflation factors, then the requisite $11 billion would be recouped by the end of the statutory 4-year timeline.[17]

Consistent with the approach discussed in the FY 2014 rulemaking for recouping the $11 billion required by ATRA § 631, in the FY 2015 IPPS/LTCH PPS final rule[18] and the FY 2016 IPPS/LTCH PPS final rule,[19] the Secretary implemented additional -0.8 percentage point recoupment adjustments to the standardized amount in FY 2015 and FY 2016, respectively. The Secretary estimated that these adjustments, combined with leaving the prior -0.8 percentage point adjustments in place, would recover up to $2 billion in FY 2015 and another $3 billion in FY 2016. When combined with the approximately $1 billion adjustment made in FY 2014, the Secretary estimated that approximately $5 to $6 billion would be left to recover under ATRA § 631 by the end of FY 2016.

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS

[12] 82 Fed. Reg. at 38008.
[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.
[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[19] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)

final rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

Once the recoupment required under ATRA § 631 was complete, the Secretary anticipated making a single positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631. However, MACRA § 414 (which was enacted on April 16, 2015) replaced the single positive adjustment the Secretary intended to make in FY 2018 with a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. In the FY 2017 rulemaking, the Secretary indicated that he would address the adjustments for FY 2018 and later fiscal years in future rulemaking. As noted previously, 21-CCA § 15005, which was enacted on December 13, 2016, amended TMA § 7(b)(1)(B) (as amended by ATRA § 631 and MACRA § 414) to reduce the adjustment for FY 2018 from a 0.5 percentage point to a 0.4588 percentage point. The Secretary believes the directive under 21-CCA § 15005 is clear and, as a result, in the FY 2018 IPPS/LTCH PPS proposed rule for FY 2018, the Secretary proposed to implement the required +0.4588 percentage point as a permanent adjustment to the standardized amount.[23]

A. The Final IPPS Rule for FY 2018

In response to the +0.4588 percentage point adjustment, several commenters reiterated their disagreement with the -1.5 percentage point adjustment that CMS made for FY 2017 under ATRA § 631, which exceeded the estimated adjustment of approximately -0.8 percentage point described in the FY 2014 IPPS/LTCH PPS rulemaking. Commenters contended that, as a result, hospitals would be left with a larger permanent cut than Congress intended following the enactment of MACRA. They asserted that CMS' proposal to apply a 0.4588 percent positive adjustment for FY 2018 misinterprets the relevant statutory authority, and urged the Secretary to align with their view of Congress' intent by restoring an additional +0.7 percentage point adjustment to the standardized amount in FY 2018 (*i.e.*, the difference between the -1.5 percentage point adjustment made in FY 2017 and the initial estimate of -0.8 percentage point discussed in the FY 2014 IPPS/LTCH PPS rulemaking). The commenters also urged the Secretary to use his discretion under 42 U.S.C. § 1395ww(d)(5)(I) to increase the FY 2018 adjustment by 0.7 percentage point. Other commenters requested that, despite current law, CMS ensure that adjustments totaling the full 3.9 percentage points withheld under ATRA § 631 be returned.[24]

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS final rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion

[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.
[23] 82 Fed. Reg. at 38009.
[24] *Id.*
[25] 81 Fed. Reg. 56783-85.

by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believes that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary notes that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

B. The FY 2019 Adjustment to the Standardized Amount

In the Final Inpatient PPS Rule for FY 2019,[29] the Secretary finalized a +0.5 percentage point adjustment to the standardized amount for FY 2019, as required under MACRA § 414.

In the final IPPS rule, several commenters argued that the Secretary misinterpreted the Congressional directives regarding the level of positive adjustment required for FY 2018 and FY 2019. The commenters contended that, while the positive adjustments required under MACRA § 414 would only total 3.0 percentage points by FY 2023, the levels of these adjustments were determined using an estimated positive ''3.2 percent baseline'' adjustment that otherwise would have been made in FY 2018. The commenters believed that, because CMS implemented an adjustment of -1.5 percentage points instead of the expected -0.8 percentage points in FY 2017, totaling -3.9 percentage points overall, the Secretary has imposed a permanent -0.7 percentage point negative adjustment beyond its statutory authority, contravening what the commenters contend was Congress' clear instructions and intent. The commenters requested that the Secretary reverse his previous position and implement additional 0.7 percentage point adjustments for both FY 2018 and FY 2019. Some of the commenters requested that the Secretary use his statutory discretion to ensure that all 3.9 percentage points in negative adjustment be restored. In addition, some of the commenters acknowledged that CMS may be bound by law but expressed opposition to the permanent reductions and requested that the Secretary refrain from making any additional coding adjustments in the future.[30]

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believes MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed

[26] *Id.* at 56784.
[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.

by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31]Moreover, as discussed in the FY 2018 IPPS final rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary does not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

C. The FY 2020 and FY 2021 Adjustments to the Standardized Amount

In both the FY 2020 IPPS Final Rule and the FY 2021 IPPS Final Rule, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
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> ***
>
> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the

[31] 78 Fed. Reg.at 50515.
[32] 83 Fed. Reg. at 41157.

> MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[33]

Similarly, in the preamble to the FY 2021 IPPS Final Rule, the Secretary stated:

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2021. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2022 through 2023 in future rulemaking.
>
> ***
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> : As we discussed in the FY 2021 IPPS/LTCH PPS proposed rule (85 FR 32471), and in response to similar comments in the FY 2020 IPPS/LTCH PPS final rule (84 FR 42057), we believe section

[33] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).

> 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114–255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2021 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act. We intend to address adjustments for FY 2022 and later years in future rulemaking.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2021.[34]

Providers' Requests for Hearing

The Providers contend whether or not the initial rate reduction was properly imposed on the FFY 2017 rates, it was improperly allowed to continue into FFYs [2018], 2020, and 2021.[35] The Providers assert FFY 2018 IPPS Final Rule improperly failed to restore the -0.7% additional

[34] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).
[35] Providers' Statement of the Group Appeal at 1.

ATRA reduction of IPPS payments imposed for FFY 2017, in violation of the TMA § 7(b)(2) prohibition against including past recoupment adjustments in the payment rates for subsequent years. The Providers argue CMS erroneously concluded that the 0.7% reduction was made permanent by MACRA and 21st CCA § 15005, and accordingly CMS implemented only the 0.4588% point adjustment to the standardized amount for FFY 2018. The Providers maintain the FFY 2019 IPPS Final Rule reiterated CMS's view that section 414 of the MACRA required a 0.5% point positive adjustment for each of the FYs 2018 through 2023, and not the single positive adjustment CMS intended to make in FY 2018, and on that basis, finalized only the 0.5% point adjustment. The Providers assert the same happened again for FFYs [2018], 2020, and 2021, CMS again improperly maintained the 0.7% additional reduction of IPPS payments that had been imposed for FFY 2017.[36]

The Providers assert Congress did not intend to create or permit a large, permanent, negative adjustment to the IPPS standardized amount in ATRA, MACRA, or the 21st CCA. The Providers argue CMS' continued refusal to refund this money is patently unlawful. The reduction in hospital payments should not be permitted to become a permanent part of the baseline calculation of the IPPS rates. The Providers contend Congress consistently retained the statutory requirement that ATRA recoupment adjustments for a single prior year shall not be included in the determination of standardized amounts for discharges occurring in a subsequent year. The Providers argue CMS' inclusion of the FFY 2017 0.7% payment reduction in the FFYs [2018], 2020, and 2021 rates cannot be sustained.

The Providers contend if CMS were permitted to adjust the standardized amount by only 0.4588% in FFY 2018 and 0.5% in FFYs 2019, 2020, and 2021 it would in effect create a permanent negative reduction of 0.9412% having nothing to do with the statutory purposes of ATRA and contrary to CMS' earlier interpretations of ATRA that were left undisputed by Congress. The Providers argue CMS must now restore at least the expired excess 0.7% adjustment that it had no business imposing in FFYs [2018], 2020, and 2021 because it is unsupported, unlawful, and ultra vires.[37]

Request for Status and Comments

On August 3, 2021, the Board issued a request for status and comments from the parties. First, the Board requested the parties file a response that provided a status update and confirmation whether the underlying providers remained committed to pursuing each case. Second, for any case that was to remain open, the parties were required to filed comments on whether EJR is appropriate pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842. The Board also declared that each case was deemed complete and required a final Schedule of Providers be filed.

On October 15, 2021, the Providers' Representative filed a Status Update indicating that the Providers are, in fact, committed to pursuing these cases. Specifically, they replied that

[36] *Id.* at 3-4.
[37] *Id.* at 4-5.

> While the Court of Appeals' decision dismissing plaintiffs-appellants' claims in *Fresno Community Hosp. and Med. Ctr. v. Azar*, 987 F.3d 158 (D.C. Cir. Feb. 9, 2021), became final earlier this year, as the Board's August 3 letter notes, we are aware of four currently-pending cases in the D.C. District Court on two documentation and coding claims that were not included in the *Fresno* appeal. *See AHMC Garfield Medical Center, LP, et al. v. Becerra*, No. 1:18-cv-02262-CKK (D.D.C.) ("*AHMC Garfield*"); *AHMC Garfield Medical Center, LP, et al. v. Becerra*, No. 1:19-cv-03569-CKK (D.D.C.); *Akron General Medical Center, LP, et al. v. Becerra*, No. 1:18-cv-01940-CKK (D.D.C.); *Alecto Healthcare Services Martin's Ferry LLC, et al. v. Becerra*, No. 1:19-cv-03808-CKK (D.D.C.) (collectively, the "post-*Fresno* cases").
>
> The *Fresno* appeal addressed only the District Court's dismissal of counts 1, 4, and 5 of the *Fresno* plaintiffs' complaint; after the District Court granted the Secretary's motion to dismiss those counts, and denied it as to counts 2 and 3, the Fresno plaintiffs voluntarily dismissed counts 2 and 3 so as to produce a final appealable decision. *See Fresno Community Hosp. and Med. Ctr. v. Azar*, No. l:18-cv-00867-CKK (D.D.C.), dismissal stipulation dated Aug. 16, 2019 and dismissal order entered Aug. 19, 2019 (both annexed). Plaintiffs in the four post-*Fresno* cases are pursuing the same allegations as counts 2 and 3 of the *Fresno* complaint (*see* annexed Joint Status Report dated May 14, 2021 and Joint Stipulation of Partial Dismissal with Prejudice and Status Report dated Aug. 6, 2021), and summary judgment motion briefing on those claims has been scheduled for later this year and early next year (*see, e.g., AHMC Garfield* docket (excerpts annexed)).

On October 29, 2021, the Providers' Representative requested the Board ***not*** grant EJR on its own motion at this time to allow the above referenced litigation to progress, since resolution of those cases may be dispositive of its pending appeals before the Board. It recognizes that the Board has granted EJR over other cases involving the same issue, but claims that allowing these cases to remain pending before the Board would allow it to focus on other appeals before the Board that are more ripe for development or resolution.

On November 1, 2021, the Medicare Contractor filed its comments. Since the Providers are directly challenging the substance of the regulations at issue, the Medicare Contractor believes that EJR is appropriate and should be granted.

Jurisdiction, Expedited Judicial Review, and Compliance with the Appropriate Cost Report Claim Requirements of 42 C.F.R. §§ 413.24(j) and 405.1873

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- They are dissatisfied with final determinations of the Medicare Contractor;

- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers are permitted to appeal from a published Federal Register;
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- the amount in controversy is, in the aggregate, $50,000 or more.[38]

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

Finally, since the Providers in these cases appealed from cost reporting periods beginning on or after January 1, 2016, they are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[39] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[40]

The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[41] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[42] The Board notes that these appeals were all taken from the publication of specific Federal Registers, and not

[38] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[39] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[40] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[41] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[42] *See* 42 C.F.R. § 405.1873(a).

NPRs issued upon receipt of a cost report. The Board further notes that no party has questioned the Providers' compliance with § 405.1873.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[43] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

In addition, the participants' documentation in the EJR requests shows that the estimated amount in controversy exceeds $50,000 in each case, as required for group appeals.[44] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers for providers with cost reports beginning on or after January 1, 2016. The estimated amount in controversy will be subject to recalculation by the Medicare contractor for the actual final amount in each case.

Board's Decision Regarding the EJR Request

The Board declines to postpone ruling on its motion for potential EJR and finds that:

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

2) Based upon the Providers' assertions regarding CMS' failure to restore an expired 0.7% reduction to Medicare IPPS rates for inpatient discharges at all IPPS hospitals, including the Providers, for the FFYs 2018, 2020, and 2021 IPPS Final Rules, 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 CMS should restore the 0.7 percent reduction to Medicare IPPS rates for inpatient discharges at all IPPS hospitals, including the Providers, for the FFYs 2018, 2020, and 2021 IPPS Final Rules.

Accordingly, the Board finds that the reduction to Medicare IPPS rates for inpatient discharges 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 all three cases, the Board hereby closes the cases. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

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[43] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[44] *See* 42 C.F.R. § 405.1835.

Board Members Participating:

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

FOR THE BOARD:

1/7/2022

X Clayton J. Nix

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

Enclosures: Schedules of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

William Galinsky
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2401 South 31st Street
MS-AR-M148
Temple, TX 76508

RE: ***Notice of Dismissal***
Baylor All Saints Medical Center (Prov. No. 45-0137)
FYE 9/30/2014
Case No. 16-1854

In connection with the above captioned case, the Provider Reimbursement Review Board ("Board") has reviewed Baylor All Saints Medical Center's ("Provider") appeal following the Board's Notice of Non-Compliance with Mandatory Electronic Filing Requirement ("Notice") issued on December 14, 2021. The Board's Notice was sent with regard to your compliance with the mandatory electronic filing requirement that went into effect November 1, 2021.[1]

On June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement:

> Effective November 1, 2021, ***all*** *submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) ***must*** *be filed electronically* using the Office of Hearings Case and Document Management System ("OH CDMS"), unless the Board grants an exemption.[2]

Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1.[3] As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties' designated representatives.

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[1] The Board's authority to mandate electronic filing is based the Final Rule published on September 18, 2020, 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020) as incorporated into the regulations at 42 C.F.R. § 405.1801(d).
[2] Board Order No. 1 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (emphasis added). Board Alert 21 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts. *See also* Board Rule 2.1.1 (Nov. 1, 2021) (stating in part: "Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").
[3] On September 30, 2021, the Board issued Board Order No. 2 to publish additional revisions to the Board Rule in order to further clarify the revisions published on June 16, 2021. However, these revisions did not impact Board Rule 2.1. *See also* Board Alert 22.

The Board's Notice informed you that it received a hard copy filing for a position paper for the above-captioned case on November 1, 2021 that did not comply with the mandatory electronic filing requirement.[4] The Board recognized that Board Alert 19 which suspended Board-set deadlines remains in effect and that the position paper was mailed for filing *prior to* November 1, 2021. However, whenever a filing is made, *it* ***must*** *comply with Board Rules*. ***Accordingly, the Board's Notice specifically stated that we will not accept your filing in hard copy format as it failed to comply with Board Rule 2.1.1***. As a result, the hard copy filing was ***not*** made part of the record for the above-captioned case.

Notwithstanding, **as a one-time courtesy**, the Board permitted you to cure the defect by filing the position paper electronically using OH CDMS ***within twenty one (21) days of the Notice's signature date (Tuesday, January 4, 2022)***. The Board further noted that *the filing deadline was* ***firm*** *and the Board specifically* ***exempted*** *it from the Board Alert 19 suspension of Board-set deadlines.* Accordingly, the Board stated that failure to meet the filing deadline may result in dismissal or other remedial action.

Board Rule 41.2 (v. 3.1, 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),**
- **if the Board is unable to contact the provider or representative at the last known address**, or
- upon failure to appear for a scheduled hearing.

Further, Board Rule 5.2 addressed the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (*see* Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;

[4] The Board Rules are available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

- Meeting the Board's deadlines; and
- Responding timely to correspondence or requests from the Board or the opposing party.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

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

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

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. **In each case, *and as appropriate*, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board**.[5]
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

[5] (Emphasis added.)

Board Decision:

Since no position paper has been timely filed in compliance with Board Rule 2.1.1 or the Board's December 14, 2021 Notice of Noncompliance, the Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case. Further, the Board notes that, to date, the Provider has not responded to the Board's December 14, 2021 Notice of Noncompliance. Accordingly, the Board hereby dismisses the case and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

1/7/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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410-786-2671

Via Electronic Delivery

William Galinsky
Baylor Scott & White Health
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Temple, TX 76508

RE: ***Notice of Dismissal***
Scott and White Brenham Hospital (Prov. No. 45-0187)
FYE: 12/31/2014
Case No. 16-1898

In connection with the above captioned case, the Provider Reimbursement Review Board ("Board") has reviewed Scott and While Brenham Hospital's ("Provider") appeal following the Board's Notice of Non-Compliance with Mandatory Electronic Filing Requirement ("Notice") issued on December 14, 2021. The Board's Notice was sent with regard to your compliance with the mandatory electronic filing requirement that went into effect November 1, 2021.[1]

On June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement:

> Effective November 1, 2021, ***all*** *submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) ***must*** *be filed electronically* using the Office of Hearings Case and Document Management System ("OH CDMS"), unless the Board grants an exemption.[2]

Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1.[3] As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties' designated representatives.

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[1] The Board's authority to mandate electronic filing is based the Final Rule published on September 18, 2020, 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020) as incorporated into the regulations at 42 C.F.R. § 405.1801(d).
[2] Board Order No. 1 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (emphasis added). Board Alert 21 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts. *See also* Board Rule 2.1.1 (Nov. 1, 2021) (stating in part: "Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").
[3] On September 30, 2021, the Board issued Board Order No. 2 to publish additional revisions to the Board Rule in order to further clarify the revisions published on June 16, 2021. However, these revisions did not impact Board Rule 2.1. *See also* Board Alert 22.

The Board's Notice informed you that it received a hard copy filing for a position paper for the above-captioned case on November 1, 2021 that did not comply with the mandatory electronic filing requirement.[4] The Board recognized that Board Alert 19 which suspended Board-set deadlines remains in effect and that the position paper was mailed for filing *prior to* November 1, 2021. However, whenever a filing is made, *it* ***must*** *comply with Board Rules*. ***Accordingly, the Board's Notice specifically stated that we will not accept your filing in hard copy format as it failed to comply with Board Rule 2.1.1***. As a result, the hard copy filing was ***not*** made part of the record for the above-captioned case.

Notwithstanding, **as a one-time courtesy**, the Board permitted you to cure the defect by filing the position paper electronically using OH CDMS ***within twenty one (21) days of the Notice's signature date (Tuesday, January 4, 2022)***. The Board further noted that *the filing deadline was* ***firm*** *and the Board specifically* ***exempted*** *it from the Board Alert 19 suspension of Board-set deadlines.* Accordingly, the Board stated that failure to meet the filing deadline may result in dismissal or other remedial action.

Board Rule 41.2 (v. 3.1, 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),**
- **if the Board is unable to contact the provider or representative at the last known address**, or
- upon failure to appear for a scheduled hearing.

Further, Board Rule 5.2 addressed the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (*see* Rule 1.1).
>
> Further, the case representative is responsible for:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;

[4] The Board Rules are available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

- Meeting the Board's deadlines; and
- Responding timely to correspondence or requests from the Board or the opposing party.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

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

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

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. **In each case, *and as appropriate*, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board**.[5]
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the merits of the provider's Medicare payment claims for each remaining issue.

[5] (Emphasis added.)

Board Decision:

Since no position paper has been timely filed in compliance with Board Rule 2.1.1 or the Board's December 14, 2021 Notice of Noncompliance, the Board finds that the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case. Further, the Board notes that, to date, the Provider has not responded to the Board's December 14, 2021 Notice of Noncompliance. Accordingly, the Board hereby dismisses this case and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

1/7/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Sentara Healthcare 2013 DSH Pre-10/1/2013 Medicaid Fraction Part C Days CIRP Grp.
Case No. 16-2482GC

Dear Ms. Webster:

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

Background

The subject CIRP group is fully formed.[1] On December 17, 2021, the Providers in the above-referenced CIRP group appeal filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue, asking the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenging said ruling.[2]

The request for CIRP group appeal was created on September 12, 2016, when the participants challenged treatment of Part C days in the Medicaid fraction of the Medicare DSH calculation

[1] The Board notes that, with respect to fully formed or complete CIRP groups, 42 C.F.R. 405.1837(e)(1) states, in pertinent part: "When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, ***no other provider under common ownership or control may appeal to the Board the issue*** that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal." (Emphasis added.)
[2] Providers' Petition for Expedited Judicial Review (Nov. 17, 2021).

for days *before* October 1, 2013.[3] The Provider also filed two other appeals for FY 2013 at the same time:

- 16-2481GC, Sentara Healthcare 2013 DSH **Post**-10/1/2013 Medicaid Fraction Part C Days CIRP Group and,
- 16-2480GC Sentara Healthcare 2013 DSH SSI Fraction Part C Days CIRP Group.

The Provider representative requested, and the Board granted, EJR in Case No. 16-2480GC on March 15, 2018. That group appeal included the *same* five providers in this group appeal.

Provider's Request for EJR

The Providers within the CIRP group appeal are challenging their Medicare reimbursement for the fiscal year 2013 cost reporting period. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[4] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[5] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[6] As such, the Providers conclude that the Board is "required" to grant EJR.[7]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[8] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[9]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[10]

[3] Request for Mandatory Group Appeal (Sep. 12, 2016).
[4] EJR Request at 1.
[5] *Id*. at 1.
[6] *Id*.
[7] *Id*. at 1-2.
[8] *Id*. at 11-12.
[9] *Id*. at 21.
[10] *Id*. at 14.

> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[11]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[12]

Board's Decision and Analysis

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

> *Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal.*[13]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[14] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

[11] *Id*. at 14.
[12] *Id*. at 17.
[13] 42 C.F.R. § 405.1837(b)(1).
[14] 42 C.F.R. § 405.1837(e)(1).

> *When the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.*[15]

Pursuant to the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e), processing of the EJR on the Board's part dictates that the group is considered fully formed; Any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[16] As Case No. 16-2482GC was part of the same common ownership, for the same issue (Part C Days), and for the same fiscal years, any providers within this case are in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

Furthermore, the Board notes that the EJR request for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Part C DSH issue, *i.e.*, both the Medicare and Medicaid fractions. Per the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"),[17] the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction.[18] This holding is controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[19] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board dismisses the DSH Part C Days issue from Case No. 16-2482GC because the issue was disposed of through the EJR of Case No. 16-2480GC, and because Case No. 16-2482GC violated the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e).

---

[15] *Id*.
[16] *See* 42 C.F.R. § 405.1837(e) ("[w]hen the Board has determined that a group appeal brought under paragraph (b)(1) of this section is fully formed, absent an order from the Board modifying its determination, no other provider under common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal.").
[17] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[18] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[19] 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).

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

Board Members Participating:

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

For the Board:

1/7/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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

RE: ***Notice of Dismissal***
Baylor Medical Center at Grapevine (Prov. No. 45-0563)
FYE 6/30/2014
Case No. 16-1768

In connection with the above-captioned case, the Provider Reimbursement Review Board ("Board") has reviewed Baylor Medical Center at Grapevine's ("Provider") appeal following the Board's Notice of Non-Compliance with Mandatory Electronic Filing Requirement ("Notice") issued on December 14, 2021. The Board's Notice was sent with regard to your compliance with the mandatory electronic filing requirement that went into effect November 1, 2021.[1]

On June 16, 2021, Board Alert 21 and Board Order No. 1 were issued by the Board to give the provider community more than 120 days' notice of this new requirement:

> Effective November 1, 2021, ***all*** *submissions* to the Board for new or pending appeals (e.g., appeal requests, correspondence, position papers) ***must*** *be filed electronically* using the Office of Hearings Case and Document Management System ("OH CDMS"), unless the Board grants an exemption.[2]

Concurrent with this notice, and effective for any filings made on or after November 1, 2021, the Board published revised Board Rules to implement this new requirement at Board Rule 2.1.1.[3] As explained in Board Rule 2.1.1, OH CDMS is a web-based portal for parties to enter and maintain their cases and to correspond with the Board. Access to a specific case is limited to the parties of that case and the parties' designated representatives.

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[1] The Board's authority to mandate electronic filing is based the Final Rule published on September 18, 2020, 85 Fed. Reg. 58432, 58986 (Sept. 18, 2020) as incorporated into the regulations at 42 C.F.R. § 405.1801(d).
[2] Board Order No. 1 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (emphasis added). Board Alert 21 is available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts. *See also* Board Rule 2.1.1 (Nov. 1, 2021) (stating in part: "Effective November 1, 2021, all filings must be submitted electronically using OH CDMS unless an exemption granted under Rule 2.1.2 applies.").
[3] On September 30, 2021, the Board issued Board Order No. 2 to publish additional revisions to the Board Rule in order to further clarify the revisions published on June 16, 2021. However, these revisions did not impact Board Rule 2.1. *See also* Board Alert 22.

The Board's Notice informed you that it received a hard copy filing for a position paper for the above-captioned case on November 2, 2021 that did not comply with the mandatory electronic filing requirement.[4] The Board recognized that Board Alert 19 which suspended Board-set deadlines remains in effect and that the position paper was mailed for filing *prior to* November 1, 2021. However, whenever a filing is made, *it* ***must*** *comply with Board Rules*. ***Accordingly, the Board's Notice specifically stated that the Board did not accept your filing in hard copy format as it failed to comply with Board Rule 2.1.1***. As a result, the hard copy filing was ***not*** made part of the record for the above-captioned case.

Notwithstanding, **as a one-time courtesy**, the Board permitted you to cure the defect by filing the position paper electronically using OH CDMS ***within five (5) business days of the Notice's signature date (i.e., no later than December 21, 2021)***. The Board further noted that QRS (as the Provider's designated representative) *is a registered user of OH CDMS, and as such since the Provider was ready to make the filing in question and the representative is a registered user of OH CDMS, the filing deadline was* ***firm*** *and the Board specifically* ***exempted*** *it from the Board Alert 19 suspension of Board-set deadlines.* Accordingly, the Board stated that failure to meet the filing deadline may result in dismissal or other remedial action. A copy of the position paper was filed electronically on December 22, 2021.

Board Rule 41.2 (v. 3.1, 2021) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- **upon failure of the provider or group to comply with Board procedures or filing deadlines (see 42 C.F.R. § 405.1868),**
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

Further, Board Rule 5.2 addressed the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - The Board's governing regulations at 42 C.F.R. Part 405, Subpart R; and
> - These Rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions (*see* Rule 1.1).
>
> Further, the case representative is responsible for:

[4] The Board Rules are available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Instructions.

- Ensuring his or her contact information is current with the Board, including a current email address and phone number;
- Meeting the Board's deadlines; and
- Responding timely to correspondence or requests from the Board or the opposing party.

Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.

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

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

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

> (b) Position papers. (1) After any preliminary narrowing of the issues, the parties must file position papers in order to narrow the issues further. **In each case, *and as appropriate*, the Board establishes the deadlines as to when the provider(s) and the contractor must submit position papers to the Board**.[5]
>
> (2) The Board has the discretion to extend the deadline for submitting a position paper. Each position paper must set forth the relevant facts and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal (as described in §405.1840 of this subpart), and the

[5] (Emphasis added.)

merits of the provider's Medicare payment claims for each remaining issue.

Board Decision:

Even though the Representative is a registered user of OH CDMS, the Representative failed to use OH CDMS to electronically file the position paper in this case in compliance with Board Rule 2.1.1 until ***after*** the deadline imposed by the Notice of Noncompliance issued on December 14, 2021. In its December 14, 2021 Notice of Noncompliance, the Board notified the Representative of its noncompliance and, as a one-time courtesy, extended the deadline to allow the Representative to cure its defective filing. Notwithstanding, the Representative missed that extended courtesy deadline and has not provided any rational for missing it. As the Provider has failed to comply with the Board's procedures, specifically the filing deadlines set in this case, on now two occasions, the Board hereby dismisses Case No. 16-1769, closes it, and removes it from the Board's docket.

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

Board Members Participating:

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

FOR THE BOARD:

1/10/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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Bill Tisdale
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RE: ***Jurisdictional Determination***
University of Colorado Hospital Authority (Prov. No. 06-0024)
FYE 06/30/2010
Case No. 15-2684

Dear Ms. Gunter and Mr. Tisdale:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the record, in response to a jurisdictional challenge filed by the Medicare Administrative Contractor ("Medicare Contractor" or "MAC"). Following review of the documentation, the Board finds that it has jurisdiction to hear the Provider's appeal for the Part C days issue.

Pertinent Facts

The Provider Reimbursement Review Board (the "Board") received the Provider's Request for Hearing on May 25, 2015.

The providers' appeal request contained the following issue statement regarding a single appealed Part C Days issue:

> The… "Provider" is dissatisfied with adjustments #20 and #44 for the SSI ratio, and adjustment #22 to remove the Protested Amount. The legal issue is whether a Medicare+Choice/Medicare Advantage (Part C) enrollee is "entitled to benefits under Part A" for purposes of the DSH calculation. The Provider contends that Medicare improperly included days associated with Medicare Part C beneficiaries in the Medicare fraction (SSI%) of the Medicare DSH calculation. The inpatient days covered under Medicare C should be excluded from the Medicare/SSI ratio, and the days should be included in the numerator of the Medicaid fraction for the Part C patients who are Medicaid eligible…..[1]

[1] Providers' Appeal Request, at Issue Statement (May 22, 2015).

In Jurisdictional Challenge filed on May 31, 2018, the Medicare Contractor challenged jurisdiction over the Part C days issue because it contends that Providers are appealing an issue that was not specifically part of any adjustment.

MAC's Challenge

The MAC contends that there are two components to Adjustment No. 20, neither of which renders a determination over the disputed issue.[2] First, the MAC updated the SSI ratio, *i.e.*, the MAC increased the Percentage of SSI Recipient Patient Days to Medicare Part A Patient Days from 10.20 to 10.32.[3] This adjustment implements the SSI ratio which was determined and published by CMS. It does not impact the *Medicaid* ratio. This component of Adjustment No. 20 does not render a determination to exclude dual eligible days Part C days from the numerator of the Medicaid fraction.

Second, the MAC argues it updated the DPP by increasing it from 19.83 to 19.93. This adjustment represents a flow-through incorporating the impact of other proposed adjustments into the DPP. This component of Adjustment No. 20 does not render a determination to exclude dual eligible days from the numerator of the Medicaid fraction. Adjustment No. 44 merely incorporates the CMS published SSI percentage for the computation of capital costs. It does not render a determination to exclude dual eligible Part C days from the numerator of the Medicaid fraction.[4]

They argue that the Provider fails to show how, in accordance with the cited statutes and regulations at 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835 results in the exclusion of dual eligible Part C days from the numerator of the Medicaid fraction. Also, it should be noted that the Medicaid fraction did not change on Line 31 of Worksheet E-Part A on either the as-filed cost report or the as-settled cost report. Both the as-filed and as-settled cost report shows a Medicaid fraction as 26.91.[5]

Finally, the MAC argues the Provider did not preserve its right to claim dissatisfaction for the disputed issue as a self disallowance in accordance with 42 CFR 405.1835(a)(1)(ii) and the procedures set forth in CMS Pub 15-2, § 115. The Protested amounts per Worksheet E-Part A, Line 30 of $1,460,258 do not include the issue of inclusion of Part C dual eligible days in the Medicaid fraction.[6]

Provider's Response

The Provider did not file a response to the challenge. Per Board Rule 44.4.3, "Providers must file a response *within thirty (30) days* of the Medicare contractor's jurisdictional challenge.

[2] MAC's Jurisdictional Challenge, at 1 (May 31, 2018).
[3] *Id*.
[4] *Id*.
[5] *Id*.
[6] *Id*.

Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."[7]

Board's Analysis and Decision

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

On August 21, 2008, new regulations governing the Board were effective.[8] 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*").[9] 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.[10]

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.

---

[7] (Emphasis added.)
[8] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[9] 201 F. Supp. 3d 131 (D.D.C. 2016).
[10] *Id.* at 142.

The D.C. Circuit has held that the Medicare statute does not speak directly to how Part C days should be treated for purposes of DSH calculations; that is, whether Part C patients are "entitled to benefits under part A" and should therefore be included in the Medicare fraction, or whether they are not so entitled, and should therefore be included in the numerator of the Medicaid fraction if they are also eligible for Medicaid.[11] The D.C. Circuit has also found that section 1886(d)(5)(F)(vi) of the Act requires the Secretary to account for Part C days in the DPP calculation by including them in one of the fractions (Medicare or Medicaid) and excluding them from the other.[12] Because the FY 2005 IPPS final rule was vacated, the Secretary "has no promulgated rule governing" the treatment of Part C days for fiscal years before 2014.[13] As a result, in order to comply with the statutory requirement to calculate Medicare DSH payments, CMS must determine, for fiscal years before 2014, whether beneficiaries enrolled in Part C are "entitled to benefits under part A" and so must be included in the Medicare fraction (and excluded from the numerator of the Medicaid fraction), or are not so entitled and so must be excluded from the Medicare fraction and included in the numerator of the Medicaid fraction, if dual-eligible.

Given the findings in *Allina* and the fact that the MAC specifically adjusted the Provider's SSI fraction, the Board finds that the adjustment to the SSI fraction is sufficient to confer Board jurisdiction. Further, given that the Provider included the SSI issue as a protested item, and satisfied the protest requirements under 42 C.F.R. § 405.1835(a)(1)(ii), as discussed above, the Board finds that it has jurisdiction over the issue. Pursuant to CMS Ruling 1739-R, the Board intends to remand the appeal under separate cover.

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

Board Members Participating:

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

For the Board:

1/10/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[11] *See Northeast Hospital Corporation v. Sebelius*, 657 F.3d 1, 13 (D.C. Cir. 2011).
[12] *See Allina Health Services v. Sebelius*, 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[13] *See Allina Health Services v. Price*, 863 F.3d 937, 939 (D.C. Cir. 2017).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Mail Stop: B1-01-31
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Via Electronic Delivery

Leslie Goldsmith, Esq.
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Washington, DC 20004

RE: ***EJR Determination***
Case No. 20-0700GC – Univ of Rochester CY 2017 DGME Penalty to FTE Count CIRP Group
Case No. 20-1093GC – Premier Health Partners CY 2016 DGME Penalty to FTE Count CIRP Grp.
Case No. 21-0922GC – UPMC CY 2017 Direct Graduate Medical Education Penalty to FTE Count CIRP Group
Case No. 21-1800GC – Univ of Rochester CY 2018 Direct Graduate Medical Education Penalty to FTE Count CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 15, 2021 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statement describes the DGME Penalty issue as follows:

> Whether the Medicare Administrative Contractor ("MAC") must correct its determinations of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency periods ("IRPs") used for determining payments for direct graduate medical education ("DGME").
>
> ***
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, 42 U.S.C. § 1395ww(h)(4)(C). The Provider disputes the computation of the current, prior and penultimate weighted DGME FTEs and the FTE cap. CMS's implementation of the cap and weighting factors is contrary to the statute, because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Provider from claiming FTEs up to its full FTE caps. See 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. §

> 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME caps are set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and residents beyond the IRPs are weighted at no more than 0.5. The Provider self-disallowed the amount at issue, because the MAC was bound to deny payment pursuant to the regulation at 42 C.F.R. § 413.79(c)(2), and the Provider challenges that regulation. See CMS-1727-R.

Background

The Medicare statute requires the Secretary[1] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[2] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[3]

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.[4]

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

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 . . .

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

> (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[5] ("*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")[6] 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.[7]

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.[8] 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:

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[5] "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).

[6] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

[7] 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.

[8] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> *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. . . .
>
> 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.[9]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[10] 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

[9] 62 Fed. Reg. at 46005 (emphasis added).
[10] 66 Fed. Reg. 39826 (Aug. 1, 2001).

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:
>
> > (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.[11]

To codify this change, the Secretary added clause (iii) to 42 § 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).[12] 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

[11] *Id.* at 39894 (emphasis added).
[12] *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 was in the prior version of the regulation and replacing it 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.[13]

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.[14]

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.[15]

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 are teaching hospitals that receive DGME payments and, during the cost years under appeal, their FTE counts exceeded their FTE caps.[16] The Providers also trained fellows and other residents who were beyond the IRP. The Providers are requesting the Board grant EJR based on a challenge to:

> the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the [DGME] cap on [FTE] residents and the FTE weighting factors. 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. The effect of the unlawful 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 the Providers from claiming their full unweighted FTE caps authorized by statute (hereinafter, the "fellowship penalty"). Thus, the

[13] 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.
[14] 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.")
[15] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[16] Providers' Petition for Expedited Judicial Review at 8 (Oct. 15, 2021) ("EJR Request").

> calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and, as a result, the Providers' DGME payments are understated.[17]

The Providers argue that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FREs are capped before application of weighting factors.[18] They claim that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this statute because it determines a cap after application of the weighting factors to fellows in the current year.[19] Second, they argue that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[20] Finally, Providers claim "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[21]

The Providers allege that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the Providers from reaching their FTE caps and treats similarly situated hospitals differently.[22] Finally, the Providers state that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[23]

The Providers claim that they meet the jurisdictional dissatisfaction requirement for this issue pursuant to CMS Ruling 1727-R and because they self-disallowed the amount sought based on the Medicare Contractor being bound by regulation.[24] They argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant their request for EJR.[25]

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) (2021), 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.

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[17] *Id.* at 1 (citations omitted).
[18] *Id.* at 11.
[19] *Id.* at 11-12.
[20] *Id.* at 12-13.
[21] *Id.* at 14.
[22] *Id.* at 16.
[23] *Id.* at 17 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-2628 (May 17, 2021).
[24] *Id.* at 8.
[25] *Id.* at 17-18.

A group of Providers generally have a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [26]
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[27]

A. Jurisdiction

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[28] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[29] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the Notice of Program Reimbursement ("NPR") issued by the MAC or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). As all of the participants in these appeals have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The participants that comprise the group appeals within this EJR determination, have filed appeals involving fiscal years 2016, 2017 and 2018. Based on its review of the record, the Board finds that each of the participants filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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[26] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[28] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[29] *Id.* at 70555.

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

All of these appeals' providers have cost reports beginning after January 1, 2016 and, thus, are subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[30] On October 18, 2021, the Board issued a Request for Information ("RFI") for either party to raise a question under 42 C.F.R. § 405.1873(a) or 42 C.F.R. § 413.24(j). On November 3, 2021, the Medicare Contractor replied to this RFI in each case identifying at least one provider with which it was raising a substantive claim challenge and, on November 22, 2021, the Providers responded.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[31] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[32] In this case, although all of the participants in the group are subject to § 413.24(j), the MAC only filed a Substantive Claim Challenge against 5 participants as set forth below.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made regarding the other remaining participants,[33] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate cost report claim was made for the other remaining participants. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for these other remaining participants. Accordingly, the Board's findings relative to compliance with the cost reporting requirements in § 413.24(j) is limited to t participants set forth below.

1. Regulatory Background

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

> (1) *General Requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost

[30] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[31] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[32] *See* 42 C.F.R. § 405.1873(a).
[33] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."

> reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[34]

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

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

[34] (Bold and underline emphasis added.)

> must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
> ***
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[35]

These regulations are applicable to the cost reporting period of all participants in these group cases. Position papers have not been filed, but following the Board's October 18, 2021 RFI, the

[35] (Bold and underline emphasis added.)

parties submitted briefs with regard to whether the impacted Providers included an appropriate cost report claim for the disputed issue.

2. Case 20-0700GC: Univ of Rochester CY 2017 DGME Penalty to FTE Count CIRP Group

This case has two providers; one appealing from an NPR and one appealing from the failure to issue a timely determination. The Medicare Contractor states that one of the Providers, Highland Hospital of Rochester ("Highland") (Provider No. 33-0164; FYE June 30, 2017), failed to include an appropriate cost report claim for the disputed issue.

It notes that Highland did not cite to a specific audit adjustment as the basis for its appeal, and that the DGME Penalty issue was not self-disallowed among the $1,307,686 of Part A Protested amounts. Since there is nothing in the record to demonstrate that Highland claimed an amount for the DGME Penalty issue as a protested amount, the Medicare Contractor contends that Highland did not include in its cost report an appropriate claim for the specific item as prescribed in 42 C.F.R. § 413.24(j).

The Provider concedes that it did not protest this issue on its Medicare cost report and that the Medicare Contractor did not implement an audit adjustment applicable to this issue. It objects to "the self-disallowance regulation at 42 C.F.R. § 413.24(j) as contrary to the jurisdictional requirements of 42 U.S.C. § 1395oo and the decisions of the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*[36] and the D.C. District Court in *Banner Heart Hosp. v. Burwell*.[37, 38]

3. Case 20-1093GC: Premier Health Partners CY 2016 DGME Penalty to FTE Count CIRP Group

The case has two providers, both of which appealing from original NPRs. The Medicare Contractor states that one of the two participating providers, Miami Valley Hospital ("Miami Valley") (Provider No. 36-0051; FYE December 31, 2016), failed to include an appropriate cost report claim for the disputed issue.

It notes that Miami Valley did not cite to a specific audit adjustment as the basis for its appeal, and that the DGME Penalty issue was not self-disallowed among the $1,478,639 of Part A Protested amounts. The only three self-disallowed items were "DSH UC Methodology", ".2% Reduction for Two Midnight rule" and "Various DSH fraction Issues." Since there is nothing in the record to demonstrate that Highland claimed an amount for the DGME Penalty issue as a protested amount, the Medicare Contractor contends that Highland did not include in its cost report an appropriate claim for the specific item as prescribed in 42 C.F.R. § 413.24(j).

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[36] 485 U.S. 399 (1988).
[37] 201 F. Supp. 3d 131, 140 (2016).
[38] PRRB Case 20-0700GC, Providers' Final Schedule of Providers and Jurisdictional Documentation at Tab 1D (July 16, 2021); PRRB Case 20-0700GC et al., Providers' Response to PRRB Request for Information at 2 (Nov. 22, 2021) ("The Providers did not file protest items on this issue.").

The Provider concedes that it did not protest this issue on its Medicare cost report and that the Medicare Contractor did not implement an audit adjustment applicable to this issue. It objects to "the self-disallowance regulation at 42 C.F.R. § 413.24(j) as contrary to the jurisdictional requirements of 42 U.S.C. § 1395oo and the decisions of the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*[39] and the D.C. District Court in *Banner Heart Hosp. v. Burwell*.[40, 41]

4. Case 21-0922GC: UPMC CY 2017 Direct Graduate Medical Education Penalty to FTE Count CIRP Group

This case has two providers, both appealing from original NPRs. The Medicare Contractor states that both providers, Magee Women's Hospital of UPMC Health System ("Magee") (Provider No. 39-0114; FYE 06/30/2017) and UMPC Presbyterian Shadyside ("Shadyside") (Provider No. 39-0164; FYE 06/30/2017) failed to include an appropriate claim for the disputed issue.

It notes that neither Magee or Shadyside cited to a specific audit adjustment as the basis for their appeals, and that the DGMS Penalty issue was not self-disallowed among the protested amounts identified with their cost reports. Since there is nothing in the record to demonstrate that either provider claimed an amount for the DGME Penalty issue as a protested amount, the Medicare Contractor contends that they did not include in its cost report an appropriate claim for the specific item as prescribed in 42 C.F.R. § 413.24(j).

The Providers concede that they did not protest this issue on their Medicare cost reports and that the Medicare Contractor did not implement any audit adjustments applicable to this issue. It objects to "the self-disallowance regulation at 42 C.F.R. § 413.24(j) as contrary to the jurisdictional requirements of 42 U.S.C. § 1395oo and the decisions of the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*[42] and the D.C. District Court in *Banner Heart Hosp. v. Burwell*.[43, 44]

5. Case 21-1800GC: Univ of Rochester CY 2018 Direct Graduate Medical Education Penalty to FTE Count CIRP Group

This case has two providers; one appealing from an NPR and one appealing from the failure to issue a timely determination. The Medicare Contractor states that one of the providers, Highland Hospital of Rochester ("Highland") (Provider No. 33-0164; FYE June 30, 2018), failed to include an appropriate cost report claim for the disputed issue.

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[39] 485 U.S. 399 (1988).
[40] 201 F. Supp. 3d 131, 140 (2016).
[41] PRRB Case 20-1093GC, Providers' Final Schedule of Providers and Jurisdictional Documentation at Tab 1D (Oct. 14, 2021); PRRB Case 20-0700GC et al., Providers' Response to PRRB Request for Information at 2 (Nov. 22, 2021) ("The Providers did not file protest items on this issue.").
[42] 485 U.S. 399 (1988).
[43] 201 F. Supp. 3d 131, 140 (2016).
[44] PRRB Case 21-0922GC, Providers' Final Schedule of Providers and Jurisdictional Documentation at Tabs 1D & 2D (Oct. 14, 2021); PRRB Case 20-0700GC et al., Providers' Response to PRRB Request for Information at 2 (Nov. 22, 2021) ("The Providers did not file protest items on this issue.").

It notes that Highland did not cite to a specific audit adjustment as the basis for its appeal, and that the DGME Penalty issue was not self-disallowed among the $1,307,686 of Part A Protested amounts. Since there is nothing in the record to demonstrate that Highland claimed an amount for the DGME Penalty issue as a protested amount, the Medicare Contractor contends that Highland did not include in its cost report an appropriate claim for the specific item as prescribed in 42 C.F.R. § 413.24(j).

The Provider concedes that it did not protest this issue on its Medicare cost report and that the Medicare Contractor did not implement an audit adjustment applicable to this issue. It objects to "the self-disallowance regulation at 42 C.F.R. § 413.24(j) as contrary to the jurisdictional requirements of 42 U.S.C. § 1395oo and the decisions of the Supreme Court in *Bethesda Hosp. Ass'n v. Bowen*[45] and the D.C. District Court in *Banner Heart Hosp. v. Burwell*.[46, 47]

6. Providers' Challenge to the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

As noted in Sections A.2-5, *supra*, the Medicare Contractor filed substantive claim challenges for the following 5 providers (the "5 Subject Providers"):

- Case 20-0700GC:
  - Highland Hospital of Rochester (Provider No. 33-0164, FYE June 30, 2017)
- Case 20-1093GC:
  - Miami Valley Hospital (Provider No. 26-0051; FYE December 31, 2016)
- Case 21-0922GC:
  - Magee Women's Hospital of UPMC Health System (Provider No. 39-0114; FYE June 30, 2017)
  - UMPC Presbyterian Shadyside (Provider No. 39-0164; FYE June 30, 2017)
- Case 21-1800GC
  - Highland Hospital of Rochester (Provider No. 33-0164; FYE June 30, 2018)

On December 10, 2021, the Board issued a Request for Comments and Notice of Own Motion EJR Relative to 42 C.F.R. §§ 413.24(j) and 405.1873. The Medicare Contractor filed its comments on December 15, 2021 and it simply contends that the Providers "failed to raise a challenge to 42 CFR § 413.24 in their appeal and, accordingly, the Board lacks jurisdiction to consider Providers' present request for expedited judicial review."[48] Should the Board disagree, the Medicare Contractor feels that EJR is appropriate since the Providers are challenging the propriety of a regulation.

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[45] 485 U.S. 399 (1988).
[46] 201 F. Supp. 3d 131, 140 (2016).
[47] PRRB Case 21-1800GC, Providers' Final Schedule of Providers and Jurisdictional Documentation at Tab 1D (Oct. 14, 2021); PRRB Case 20-0700GC et al., Providers' Response to PRRB Request for Information at 2 (Nov. 22, 2021) ("The Providers did not file protest items on this issue.").
[48] Response to Board Request for Information and Scheduling Order (Dec. 15, 2021).

In response to the Board's second RFI, "the Providers urge that the Board grant EJR as it relates to 42 C.F.R. §§ 413.24(j) ***and*** 405.1873[.]"[49] They claim that these regulations contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that "[n]owhere in that statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board."[50] The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp 3d 131, 140 (2016). They argue that "[t]he 2016 self-disallowance regulation at 42 C.F.R. 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation."[51]

In response to the Medicare Contractor's argument that the Board lacks jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (*on its own motion* or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[52]

With regard to the 5 Subject Providers, the Board finds that it ***does*** have jurisdiction over their challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. While the Medicare Contractor argues that the issue was not specifically appealed, the Board notes that including a challenge to these regulations in the 5 Subject Providers' initial appeals would have been premature. As discussed above, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[53] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[54] Accordingly, a potential challenge to those regulations *only* became relevant once the Medicare Contractor filed its Substantive Claim Challenges to trigger Board review of compliance with those regulations.

7. Appropriate Cost Report Claim: Findings of Fact and Conclusions of Law

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[55] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its

[49] Providers' Supplemental Response to PRRB Request for Information, 2 (Dec. 17, 2021) (emphasis added).
[50] *Id.* at 3.
[51] *Id.* at 5.
[52] *Id.* at 6.
[53] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[54] *See* 42 C.F.R. § 405.1873(a).
[55] (Emphasis added.)

specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

It is undisputed that the 5 Subject Providers failed to specifically claim or otherwise protest the issue disputed in these group appeals. Based on the above, the board finds that the following providers failed to specifically include a substantive claim for the DGME Penalty Issue issue as required under 42 C.F.R. § 413.424(j)(1):

- Case 20-0700GC:
  - Highland Hospital of Rochester (Provider No. 33-0164; FYE June 30, 2017)
- Case 20-1093GC:
  - Miami Valley Hospital (Provider No. 36-0051; FYE December 31, 2016)
- Case 21-0922GC:
  - Magee Women's Hospital of UPMC Health System (Provider No. 39-0114; FYE 06/30/2017)
  - UMPC Presbyterian Shadyside (Provider No. 39-0164; FYE 06/30/2017)
- Case 21-1800GC:
  - Highland Hospital of Rochester (Provider No. 33-0164; FYE June 30, 2018)

Finally, the Board finds that, since there is no factual dispute regarding the 5 Subject Providers' lack of compliance with 42 C.F.R. § 413.24(j), the Board is bound by the regulation at 42 C.F.R. §§ 413.24(j) and 405.1873 (pursuant to 42 C.F.R. §405.1867) and does not have the authority to review their validity. Accordingly, EJR of the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is appropriate and the Board, on its own motion, hereby, grants EJR on that challenge.

C. 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 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 formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in its request for EJR used to calculate the allowable count for primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [56]

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

[56] EJR Request at 4.

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.[57] 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.[58] 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].[59]

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.[60] 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

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[57] *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.)).
[58] 66 Fed. Reg. at 39894 (emphasis added).
[59] (Emphasis added.)
[60] *See* 62 Fed. Reg. at 46005 (emphasis added).

mechanism for implementing the statutory provision."[61] 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[62] (*i.e.*, ratios) using variables a, b, c, and 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.[63]

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.

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[61] *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.)).

[62] 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.

[63] 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.

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). 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.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over both the DGME Penalty Issue ***and*** the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the subject years and that the Providers in these appeals are entitled to a hearing before the Board;

2) The following participants appealed cost reporting periods beginning on January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1):

   - Case 20-0700GC:
     - Highland Hospital of Rochester (Provider No. 33-0164; FYE June 30, 2017)
   - Case 20-1093GC:
     - Miami Valley Hospital (Provider No. 36-0051; FYE December 31, 2016)
   - Case 21-0922GC:
     - Magee Women's Hospital of UPMC Health System (Provider No. 39-0114; FYE 06/30/2017)
     - UMPC Presbyterian Shadyside (Provider No. 39-0164; FYE 06/30/2017)
   - Case 21-1800GC:
     - Highland Hospital of Rochester (Provider No. 33-0164; FYE June 30, 2018)

3) Based upon the Provider's assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, there are no findings of fact for resolution by the Board;

4) It is bound by the applicable existing Medicare law and regulation (42 C.F.R. § 405.1867); and

5) It is without the authority to decide the legal questions of:

   a. Whether 42 C.F.R. § 413.79(c)(2)(iii) is valid; ***and***
   b. Whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the questions regarding the validity of 42 C.F.R. § 413.79(c)(2)(iii) and 42 C.F.R. §§ 413.24(j) and 405.1873 properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the DGME Penalty issue and the subject years. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 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.

Board Members Participating:

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

FOR THE BOARD:

1/13/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators
Danelle Decker, National Government Services, Inc)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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410-786-2671

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Prince William Hospital (Prov. No. 49-0045)
FYE 12/31/2011
Case No. 16-0095

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 Issue 1, the DSH/SSI (Provider Specific) issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 22, 2015, the Board received Provider's Individual Appeal Request appealing their May 6, 2015 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2011. The initial appeal contained these two issues:

1. DSH/SSI (Provider Specific)
2. DSH Payment- Medicaid Eligible Days

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.

> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[1]

The Provider filed a Final Position Paper (Oct. 30, 2021) ("FPP") in which they describe Issue 1, the DSH/SSI (Provider Specific) issue, as

> 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 based on the Provider's Fiscal Year End (December 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. See 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[2]

[1] Individual Appeal Request, Issue 1.
[2] Provider's Final Position Paper (Oct. 30, 2021) at 8-9.

On October 22, 2015, the Provider requested to be directly added to the common issue related party ("CIRP") group under Case No. 15-1576GC entitled "QRS Novant 2011 SSI Percentage Group." Specifically, the Provider filed a Model Form E "Request to Join Existing Group Appeal: Direct Appeal From Final Determination" in Case No. 14-1476GC and the final determination referenced on the Model Form E is the Provider's May 6, 2015 Notice of Program Reimbursement. The group issue statement issue under appeal in Case No. 15-1576GC is as follows:

> The Providers contend that the lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the lead MAC to settle their Cost Report does not address all of the deficiencies as described in *Baystate Medical Center v. Leavitt,* 545 F. Supp. 2d 20, *as amended,* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Paid days vs. Eligible Days
> 3. Not in agreement with provider's records
> 4. Fundamental problems in the SSI percentage calculation
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[3]

On November 10, 2021, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor in this appeal which argued that the Board lacks jurisdiction over Issue 1, the DSH/SSI (Provider Specific) issue, because the portion of the issue concerning SSI data accuracy is duplicative of the group appeal issue in the CIRP group under Case No. 15-1576GC and this Provider was directly added to Case No. 15-1576GC. The Medicare Contractor also argues that the Board should dismiss the portion of Issue 1 pertaining to realignment because it is no longer relevant as CMS has already recalculated the SSI percentage based on the Provider's fiscal year end of December 31, 2011. Also, the Medicare Contractor issued an Amended Notice of Amount of Program Reimbursement on July 10, 2019.[4]

[3] CN 15-1576GC, Group Appeal Request, Exhibit 2 "Group Issue."
[4] Medicare Administrative Contractor's Jurisdictional Challenge at 1-2 (Nov. 10, 2021).

The Provider did not file a response to the Medicare Contractor's Jurisdictional Challenge. Per Board Rule 44.4.3 states: "Providers must file a response *within thirty (30) days* of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination *with the information contained in the record*."[5]

Board Decision:

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

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue in Group Case No. 15-1576GC to which the Provider was directly added.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of the Group Issue (the DSH/SSI (Systemic Errors) issue) that is contained in Case No. 15-1576GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[6] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[7] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[8] The issue under appeal in group Case

[5] (Emphasis added.)
[6] Individual Appeal Request, Issue 1.
[7] *Id.*
[8] *Id.*

No. 15-1576GC similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the Group Issue in Case No. 15-1576GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-1576GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[9] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-1576GC.

To this end, the Board staff also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the Group Issue in Case No. 15-1576GC. Accordingly, the Board finds that the Provider FPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[10] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its FPP and include *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[11] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its FPP on June 12, 2021 in direct violation of Board Rule 25.2.2:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the

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

> documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

The perfunctory nature of the Provider's FPP is further highlighted by the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the CMS on a "*self-service*" basis as documented at the following webpages but fail to discuss the information that is available:

1. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Nov. 17, 2021); and

2. https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Nov. 17, 2021) (CMS webpage describing access to DSH data ***from 1998 to 2017***: "DSH is now a self-service application. This new ***self-service*** process enables you to enter your data request(s) and retrieve your data files through the CMS Portal." (emphasis added)).

Accordingly, the Board must find that Issue 1 in this appeal, and the group issue in Group Case No. 15-1576GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its FPP in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ." The Provider requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3) on May 2, 2018.[12] The Provider's cost report was then reopened, and the Provider received an Amended Notice of Program Reimbursement dated July 10, 2019 which contained a new SSI percentage based upon the Provider's fiscal year end.[13] Thus, the Provider has already pursued the appropriate administrative remedy, and received a new SSI percentage based upon its fiscal year end. Thus, the Board dismisses the issue from the appeal.

[12] Medicare Contractor's Jurisdictional Challenge, Exhibit C-6.
[13] Medicare Contractor's Jurisdictional Challenge, Exhibit C-9.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Case No. 16-0095 remains open given that another issue, DSH Payment – Medicaid Eligible Days, remains pending.

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

Board Members Participating:

Clayton J. Nix, Esq.
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For the Board:

1/21/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Jurisdictional Decision***
Scott & White Memorial Hospital (Prov. No. 45-0054)
FYE 8/31/2011
Case No. 17-0299

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 Issue 1, the DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 31, 2016, the Board received Provider's Individual Appeal Request appealing their May 4, 2016 Notice of Program Reimbursement ("NPR") for fiscal year ending August 31, 2011. The initial appeal contained the nine (9) following issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
4. DSH Payment – SSI Fraction/Dual Eligible Days
5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
6. DSH Payment – Medicaid Fraction/Dual Eligible Days
7. DSH Payment – Medicaid Eligible Days
8. DSH Payment – Medicare Managed Part C Days
9. DSH Payment – Dual Eligible Days

On June 21, 2017, Issues 2, 3, 4, 6, 8 and 9 were transferred to group appeals. In particular, Issue 2 was transferred to the optional group under Case No. 15-0733GC. As a result, there are two remaining issues: Issue 1- DSH/SSI Percentage (Provider Specific) and Issue 5 – DSH Medicaid Eligible Days.

In its appeal request, the Provider summarized Issue 1, the DSH/SSI – Provider Specific issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individual that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

Similarly, the Provider described Issue 2, the DSH/SSI Percentage issue (which, as previously noted, has been transferred to a Case No. 15-0733GC) as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider further contends that the SSI

[1] Individual Appeal Request, Issue 1.

> percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individual that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 S. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 D.D.C. 2008) an incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days[2]

The Provider submitted its Final Position Paper on August 26, 2021.

On April 23, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH/SSI (Provider Specific) issue) because it is duplicative of Issue 2 (the DSH/SSI issue), which was transferred to Case No. 15-0733GC.

On May 24, 2018, the Provider filed its response to the jurisdictional challenge. In its response, the Provider maintains that Issue 1 is distinct and separate from Issue 2 because Issue 1 (the

[2] *Id.* at Issue 2.

DSH/SSI Provider Specific issue) it is "not addressing the errors which result from CMs' improper data matching process but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category." In support of its position, the Provider cites to the D.C. District Court's decision in *Baystate* and contends that, "[i]n Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio."[3] The Provider further states that it "has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI" and "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio." It later states that it "has ***specifically*** identified patients believed to be entitled to both Medicare Part A and SSI who were not include in the SSI percentage determined by CMS, due to errors that are or may be specific to the provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation" but, in the next sentence, backtracks by stating "[o]nce these patient are identified, the Provider contents that it will be identified to a correction of these errors of omission to its SSI percentage."[4]

Board Decision:

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

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 15-0733GC.

[3] Provider's Jurisdictional Response at 2 (May 24, 2018) (citing *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[4] (Emphasis added and generic citation to *Baystate* omitted.)

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 15-0733GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[5] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[6] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[7] Issue 2, transferred to the group under Case No. 15-0733GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 15-0733GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-0733GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[8] In particular, the issues in the *Baystate* case regarding non-cash SSI benefits[9] and the omission of hold and suspense SSI categories were discussed in the context of the data match process and the Agency's accounting therein of retroactive corrections that resulted in the retroactive payment of

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

> According to Shafer, this problem could easily be fixed. He explained that the signal for a forced pay situation is a C01 or M01 code in the CMPH field and $0 due in the FAM and State amount ("SAM") fields. This situation only occurs when an individual is receiving a forced payment or non-cash benefits under section 1619(b) of the Social Security Act (these latter benefits are discussed further below).151 SSA's computer program, therefore, could easily be written to create a "loop" to go back and check an individual's earlier records whenever it comes across a C01 or M01 in the CMPH field and no amount due in the FAM and SAM fields.

Baystate Med. Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 at 27 (Mar. 17, 2006) (footnotes omitted).

benefits as captured in SSI payment codes M1, C01 or C02.[10] Accordingly, the Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-0733GC.

To this end, the Board also reviewed the Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider FPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[11] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[12] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its initial appeal was filed in direct violation of Board Rule 25.2.B:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available.

---

[10] *See id*. at 23-30. Indeed, the Secretary discusses the very issues in the revised data matching process published in the FY 2011 IPPS final rule. 75 Fed. Reg. 50042, 50282-83 (Aug. 16, 2010) (stating: "We believe that, by calculating SSI fractions on the basis of SSI eligibility data and MedPAR claims data that are updated 15 months after the end of the Federal fiscal year, we would be using the best data available to us, given the deadlines for the submission and final settlement of Medicare cost reports. . . . We believe that our proposed timing of the data match would achieve an appropriate balance between ***accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions*** using all timely submitted Part A inpatient claims, and facilitating administrative finality through the timely final settlement of Medicare cost reports. (emphasis added)). *See also id.* at 50284 (stating: (1) "We believe that our proposal to conduct the SSI eligibility match and calculate the SSI fractions 15 months after the end of the Federal fiscal year will ensure that the SSI fractions are calculated with the best data available to us at that time. We note that the 15- month timeframe proposed is an approximation and subject to the data validation protocols as described previously in this final rule. We believe that the match will be conducted no sooner than 15 months after the end of the Federal fiscal year and the match process, including all appropriate validation steps as finalized, will be performed as efficiently as possible and in accordance with the production cycles of the required data files."; and (2) "Although the deadline for the timely filing of claims is 12 months after the end of the Federal fiscal year, we are finalizing our proposal to conduct the data matching process and calculate SSI fractions approximately 15 months after the end of the Federal fiscal year to ensure we have captured all of the inpatient claims and to capture as many retroactive SSI entitlement determinations as possible.").

[11] (Emphasis added.)

[12] (Emphasis added.)

> Once the documents become available, promptly forward them to the Board and the opposing party.

The perfunctory nature of the Provider's FPP is further highlighted by the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the CMS on a "*self-service*" basis as documented at the following webpages but fail to discuss the information that is available:

1. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Nov. 17, 2021); and

2. https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Nov. 17, 2021) (CMS webpage describing access to DSH data ***from 1998 to 2017***: "DSH is now a self-service application. This new ***self-service*** process enables you to enter your data request(s) and retrieve your data files through the CMS Portal." (emphasis added)).

Accordingly, the Board must find that Issues 1 and 2, which was transferred to Group Case No. 15-0733GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its FPP in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Additionally, the Provider's Fiscal Year End is the same as the Federal fiscal year end, and the request for realignment is illogical. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Case No. 17-0299 remains open given that another issue, DSH Payment – Medicaid Eligible Days, remains pending.

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

Board Members Participating:

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

For the Board:

1/21/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdictional Decision***
Scott & White Memorial Hospital (Prov. No. 45-0054)
FYE 8/31/2012
Case No. 18-0102

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 Issue 1, the DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 19, 2017, the Board received Provider's Individual Appeal Request appealing their April 28, 2017 Notice of Program Reimbursement ("NPR") for fiscal year ending August 31, 2012. The initial appeal contained the seven (7) following issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
4. DSH Payment – SSI Fraction/Dual Eligible Days
5. DSH Payment – Medicaid Eligible Days
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days

On June 29, 2018, Issues 2, 3, 4, 6, and 7 were transferred to group appeals. In particular, Issue 2 was transferred to the optional group under Case No. 15-3173GC. As a result, there are only two remaining issues: Issue 1- DSH/SSI Percentage (Provider Specific) and Issue 5 – DSH Medicaid Eligible Days.

In its appeal request, the Provider summarizes Issue 1, the DSH/SSI – Provider Specific issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individual that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[1]

Similarly, the Provider described Issue 2, the DSH/SSI Percentage issue (which, as previously noted, has been transferred to a Case No. 15-3173GC) as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider further contends that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports were incorrectly computed.

[1] Individual Appeal Request, Issue 1.

> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individual that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 S. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 D.D.C. 2008) an incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Failure to adhere to required notice and comment rulemaking procedures
> 3. Fundamental problems in the SSI percentage calculation
> 4. Not in agreement with provider's records
> 5. Paid days vs. Eligible Days, and
> 6. Covered days vs. Total days[2]

The Provider submitted its Final Position Paper on April 23, 2021.

On April 11, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH/SSI (Provider Specific) issue) because it is duplicative of Issue 2 (the DSH/SSI issue), which was transferred to Case No. 15-3173GC.

On May 29, 2018, the Provider filed its response to the jurisdictional challenge. In its response, the Provider maintains that Issue 1 is distinct and separate from Issue 2 because Issue 1 (the DSH/SSI Provider Specific issue) it is "not addressing the errors which result from CMs'

[2] *Id.* at Issue 2.

improper data matching process but is addressing the various errors of omission and commission that do not fit into the 'systemic errors' category." In support of its position, the Provider cites to the D.C. District Court's decision in *Baystate* and contends that, "[i]n Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio."[3] The Provider further states that it "has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI" and "has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio." It later states that it "has ***specifically*** identified patients believed to be entitled to both Medicare Part A and SSI who were not include in the SSI percentage determined by CMS, due to errors that are or may be specific to the provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation" but, in the next sentence, backtracks by stating "[o]nce these patient are identified, the Provider contents that it will be identified to a correction of these errors of omission to its SSI percentage."[4]

Board Decision:

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

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 15-3173GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to

[3] Provider's Jurisdictional Response at 2 (May 29, 2018) (citing *Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[4] (Emphasis added and generic citation to *Baystate* omitted.)

Case No. 15-3173GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[5] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[6] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[7] Issue 2, transferred to the group under Case No. 15-3173GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 15-3173GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 15-3173GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[8] In particular, the issues in the *Baystate* case regarding non-cash SSI benefits[9] and the omission of hold and suspense SSI categories were discussed in the context of the data match process and the Agency's accounting therein of retroactive corrections that resulted in the retroactive payment of benefits as captured in SSI payment codes M1, C01 or C02.[10] Accordingly, Provider is

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

> According to Shafer, this problem could easily be fixed. He explained that the signal for a forced pay situation is a C01 or M01 code in the CMPH field and $0 due in the FAM and State amount ("SAM") fields. This situation only occurs when an individual is receiving a forced payment or non-cash benefits under section 1619(b) of the Social Security Act (these latter benefits are discussed further below).151 SSA's computer program, therefore, could easily be written to create a "loop" to go back and check an individual's earlier records whenever it comes across a C01 or M01 in the CMPH field and no amount due in the FAM and SAM fields.

Baystate Med. Ctr. v. Mutual of Omaha Ins. Co., PRRB Dec. No. 2006-D20 at 27 (Mar. 17, 2006) (footnotes omitted).
[10] *See id.* at 23-30. Indeed, the Secretary discusses the very issues in the revised data matching process published in the FY 2011 IPPS final rule. 75 Fed. Reg. 50042, 50282-83 (Aug. 16, 2010) (stating: "We believe that, by

misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 15-3173GC.

To this end, the Board also reviewed the Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from Issue 2. Accordingly, the Board finds that the Provider FPP failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[11] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[12] However, the Provider simply states again it is "seeking [MEDPAR data] from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage" but fails to give any update on those efforts since it filed its initial appeal was filed in direct violation of Board Rule 25.2.B:

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

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calculating SSI fractions on the basis of SSI eligibility data and MedPAR claims data that are updated 15 months after the end of the Federal fiscal year, we would be using the best data available to us, given the deadlines for the submission and final settlement of Medicare cost reports. . . . We believe that our proposed timing of the data match would achieve an appropriate balance between ***accounting for additional retroactive SSI eligibility determinations and the lifting of SSI payment suspensions*** using all timely submitted Part A inpatient claims, and facilitating administrative finality through the timely final settlement of Medicare cost reports. (emphasis added)). *See also id.* at 50284 (stating: (1) "We believe that our proposal to conduct the SSI eligibility match and calculate the SSI fractions 15 months after the end of the Federal fiscal year will ensure that the SSI fractions are calculated with the best data available to us at that time. We note that the 15- month timeframe proposed is an approximation and subject to the data validation protocols as described previously in this final rule. We believe that the match will be conducted no sooner than 15 months after the end of the Federal fiscal year and the match process, including all appropriate validation steps as finalized, will be performed as efficiently as possible and in accordance with the production cycles of the required data files."; and (2) "Although the deadline for the timely filing of claims is 12 months after the end of the Federal fiscal year, we are finalizing our proposal to conduct the data matching process and calculate SSI fractions approximately 15 months after the end of the Federal fiscal year to ensure we have captured all of the inpatient claims and to capture as many retroactive SSI entitlement determinations as possible.").

[11] (Emphasis added.)

[12] (Emphasis added.)

The perfunctory nature of the Provider's FPP is further highlighted by the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the CMS on a "*self-service*" basis as documented at the following webpages but fail to discuss the information that is available:

1. https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh (last accessed Nov. 17, 2021); and

2. https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH (last accessed Nov. 17, 2021) (CMS webpage describing access to DSH data ***from 1998 to 2017***: "DSH is now a self-service application. This new ***self-service*** process enables you to enter your data request(s) and retrieve your data files through the CMS Portal." (emphasis added)).

Accordingly, the Board must find that Issues 1 and 2, which was transferred to Group Case No. 15-3173GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its FPP in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Additionally, the Provider's Fiscal Year End is the same as the Federal fiscal year end, and the request for realignment is illogical. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Case No. 18-0102 remains open given that another issue, DSH Payment – Medicaid Eligible Days, remains pending.

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

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RE: ***Jurisdictional Decision*** **– Pre and Post-10/1/2013 Part C Days**
16-1179G Toyon 2013 Exclusion of Dual Eligible Part C Days from the Medicaid Ratio Grp.
16-1182G Toyon 2013 Inclusion of Medicare Part C Days in the SSI Ratio Group

Dear Mr. Chinea and Ms. Frewert:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the optional group cases under Case Nos. 16-1179G and 16-1182G. The Board's decision is set forth below.

Background

The Board received the Group Representative's Requests for Hearing dated March 2, 2016, for both optional groups. On October 30, 2020, the Providers in both appeals requested Expedited Judicial Review ("EJR"). On November 27, 2020, the Board denied the EJR requests because the cases were subject to remand (via CMS Ruling 1739-R) which would be received under separate cover.

The Providers' appeal requests included issue statements concerning the exclusion of Dual Eligible Part C Days from the Medicaid Ratio, and Inclusion of Medicare Part C Days in the Medicare/SSI percentage.[1] Both groups were formed with the same two providers (Enloe Medical Center and Valley Memorial Hospital) and both of these providers appealed their FYE 6/30/2013. As such, the initial participants appealed FYEs that ***only*** had discharges dates *before* 10/1/2013.

Additional providers were added to the groups. In March 2017, the groups became fully formed. As a result, both groups now contains the following Providers that have appealed FYEs containing discharge dates both *before* and *after* 10/1/2013:

- Community Hospital of the Monterey Peninsula (05-0145, **12/31/2013**)
- Delano Regional Medical Center (05-0608, **12/31/2013**)

[1] Providers' Optional Group Appeal Request, at 1 (Mar. 2, 2016), PRRB Case no. 16-1179G; *See also* PRRB Case no. 16-1182G.

- Doctors Medical Center (05-0079, **12/31/2013**)
- Marshall Hospital (05-0254, **10/31/2013**)
- Harrington Memorial Hospital (05-0438, **12/31/2013**)

The remaining Providers in each group appealed from 6/30/2013 FYEs and, as such, all discharge dates occur ***before*** 10/1/2013.

Board's Analysis and Decision

Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[2] Thus, the disposition of the DSH Part C Days – Medicare/SSI Fraction issue dictates the disposition of the DSH Part C Days – Medicaid Fraction issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

Pursuant to Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Board must remand the Part C days issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates ***before*** October 1, 2013."[3]

Requirement for a single issue in a group appeal

Pursuant to the Board Rules issued on July 1, 2015, active at the time these appeals were filed, Board Rule 13 notes that there must be single common group issue:

> The matter at issue must involve a single common question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group….[4]

Within these groups, each group participant contends CMS' new interpretation of including Medicare Advantage or Part C Days in the SSI ratio is tantamount to retroactive rulemaking.

A group can only have one issue and that issue must be common to ***all*** providers in the group. At issue, then, is whether the pre-10/1/2013 and on or after 10/1/2013 Part C days are distinct issues. In *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019), the Court noted that:

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[2] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.
[3] Emphasis added; *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).
[4] PRRB Board Rule 13 (Jul. 1, 2015).

> The agency overseeing Medicare has gone back and forth on whether to count Part C participants in the Medicare fraction. At first, it did not include them. See *Northeast Hospital Corp. v. Sebelius*, 657 F. 3d 1, 15–16 (CADC 2011). In 2003, the agency even proposed codifying that practice in a formal rule. 68 Fed. Reg. 27208. But after the public comment period, the agency reversed field and issued a final rule in 2004 declaring that it would begin counting Part C patients. 69 Fed. Reg. 49099. This abrupt change prompted various legal challenges from hospitals. In one case, a court held that the agency couldn't apply the 2004 rule retroactively. *Northeast Hospital*, 657 F. 3d at 14. In another case, a court vacated the 2004 rule because the agency had " 'pull[ed] a surprise switcheroo' " by doing the opposite of what it had proposed. *Allina Health Services v. Sebelius*, 746 F. 3d 1102, 1108 (CADC 2014). Eventually, and in response to these developments, the agency in 2013 issued a new rule that prospectively "readopt[ed] the policy" of counting Part C patients. 78 Fed. Reg. 50620. Challenges to the 2013 rule are pending.[5]

The Court here places a clear delineation between before and after the 2013 rule was enacted by CMS. In response to Allina, CMS issued Ruling 1739-R.[6] Key within the ruling, it states:

> CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina. This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare CMS-1739-R 2 and Medicaid fractions of the disproportionate patient percentage; ***this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule***. The Ruling requires that the PRRB remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor. The Ruling explains that Medicare contractors will then

[5] *Azar v. Allina Health Services*, 139 S. Ct. 1804, 1809-10 (2019).
[6] CMS Ruling 1739-R (Aug. 17, 2020).

> calculate the provider's disproportionate share hospital (DSH) payment adjustment pursuant to the forthcoming final rule.[7]

Given the decision of the Supreme Court, as well as CMS' treatment of the days in Ruling 1739-R, it is clear that Part C days, before and after the October 1, 2013 date are distinct issues that are governed by different regulatory provisions. As distinct issues, the Board looks to the Providers' documentation and issue statements to determine which time period is being challenged in a specific appeal.

The group issue statement states the following, suggesting that the Providers are not contesting the post-10/1/2013 period:

> The Secretary did not validly change her interpretation of the DSH calculation *prior to FFY 2013*, and because there is no statute that authorizes the Secretary to promulgate retractive rules for DSH calculations, the Secretary cannot impose her new interpretation on the DHS payment calculation challenged in this case.[8]

It is clear that the group issue for these providers is limited to Part C days *before* the 10/1/2013 cutoff date.[9] To this end, the initial 2 participants that formed each group appealed FYEs that only had discharge dates prior to 10/1/2013 (specifically they appealed the FYE 6/30/2013). As such, any Part C days *on or after* October 1, 2013, must be a separate issue, and as the Board rules prohibit two issues in a group, would be prohibited in these appeals. Further review notes that there is no support that the providers presented any argument regarding any days on or after 10/1/2013. Accordingly, the Board finds that the group issue statement does not include a separate Part C issue for post-10/1/2013 days but rather that the group appeal is limited to pre-10/1/2013 Part C days.

Even if the Board were to find that the issue statement included two issues, it would not have been a proper group issue statement because it would have not applied *all* participants in the group as required by the regulations governing optional groups.[10] Indeed, it would not have been applicable to the initial 2 participants that initially formed the group since they each appealed a fiscal year that did ***not*** have any discharges on or after 10/1/2013. Moreover, each group contains multiple other providers appealing from 6/30/2013 fiscal periods that would not have any discharges for the post-10/1/2013 period in these appeals. Accordingly, the post-10/1/2013 issue is not eligible for bifurcation since it was never properly part of the group as evidenced by the fact that the founding participants did not have the post-10/1/2013 issue and it is not common to all of providers in the fully formed groups. In this regard, 42 C.F.R. § 404.1837(f)(2)(ii) makes clear that bifurcation only applies when the additional issue is common to all providers in the group: "When the appeal is found to involve more than one factual or legal question ***common to each provider***, the Board

[7] *Id*. at 1-2. (emphasis added).
[8] Emphasis added; Provider's Optional Group Appeal Request, at 1 (Mar. 2, 2016), PRRB Case no. 16-1179G; *See id.* at PRRB Case no. 16-1182G.
[9] (Emphasis added.)
[10] *See* 42 C.F.R. § 405.1837(b)(2), (f)(2).

must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[11]

Based on the above findings, the Board hereby concludes that the post-10/1/2013 Part C issue was ***never*** part of the optional groups (and, to any extent it could be otherwise construed as such, would dismiss it as improperly part of the group and not eligible for bifurcation). The Board further finds jurisdiction for the pre-10/1/2013 Part C days issue and the Providers will be remanded pursuant to CMS Ruling 1739-R under separate cover. 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.

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cc: Wilson Leong, Federal Specialized Services

Appendix A

[11] (Emphasis added.)

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RE: ***Expedited Judicial Review Decision***
Lincoln Trail Behavior Health (Prov. No. 18-4012)
FYE 4/30/17
Case No. 19-1917

Dear Ms. Elias:

On January 30, 2020, in connection with the above-referenced appeal involving Lincoln Trail Behavior Health ("Provider" or "Lincoln Trail"), the Provider Reimbursement Review Board ("Board") issued a Scheduling Order for the briefing of jurisdiction as well as setting deadlines for the filing of any substantive claim challenges made pursuant to 42 C.F.R. § 405.1873(a). The parties filed responses on February 27, 2020, March 2, 2020 and March 26, 2020 to the Board's January 30, 2020 Scheduling Order. On September 1, 2021, the Board issued preliminary determinations regarding jurisdiction and the substantive claim challenge filed by the Medicare Contractor ("MAC").[1] The September 1, 2021 letter also served as notice to the parties that the Board is considering an own-motion expedited judicial review ("EJR") of certain questions that Lincoln Trail raised in its March 26, 2020 filing.

On November 14, 2021, the Board issued a Request for Information ("RFI") with respect to the substantive issue for which the Provider has requested EJR. Specifically, the Board requested that Lincoln Trail submit a filing that:

[1] On September 27, 2021, the Board clarified that:

> its letter issued on September 1, 2021 was issued, pursuant to 42 C.F.R. 405.1873(b)(1), to provide the Board's factual and legal findings on whether the cost report at issue included an appropriate claim for the specific item at issue was made under were issued pursuant to 42 C.F.R. 405.1873(b)(1). However, the Board's September 1, 2021 letter is ***not*** *a final disposition of the case* because the letter did not address satisfaction of "the other substantive reimbursement requirements" at issue in the case as would be evidenced by a decision issued pursuant to 42 C.F.R. 402.1873(d), (f). In this regard, 42 C.F.R. 402.1873(d), (f) makes clear it that final disposition does not occur until the Board addresses satisfaction of the "other substantive requirements" at issue in the case and, as noted in the Board's September 1, 2021 letter, the Provider's EJR request (which addresses, in part, the satisfaction of those "other substantive requirements" at issue) was then incomplete. Accordingly, review of the Board's September 1, 2021 letter may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 but not until final disposition of the appeal . . . .

a. Identified, by FFY(s), which IPF PPS rates were being challenged, and, identified which Federal Register provisions published or finalized the wage index used in those IPF PPS rates being challenged;

b. Confirmed whether the alleged errors in the wage data for Hardin Memorial Hospital ("Hardin") impacted the IPPS wage index that was used to set the IPF PPS rates identified in No. 1;

c. Explained, in additional detail, whether it was challenging the underlying policy of the calculation of the wage index, and, if so, the specific policy(ies) being challenged; and

d. Demonstrated that there were no factual issues in dispute.

Lincoln Trail filed its response with the Board on December 2, 2021, and the MAC filed its response to Lincoln Trail's filing on December 30, 2021.

Lincoln Trail's 12/2/2021 Response to the Board's RFI

In its response, Lincoln Trail addressed each of the Board's requests in turn. With respect to the wage index determination under appeal, the Provider confirmed that the Inpatient PPS FFY 2015 wage index was used to compute the Inpatient Psych PPS for FFY 2016.[2] For the discharges from May 1, 2016 through September 30, 2016, Provider's Inpatient Psych PPS payments were based on the FFY 2016 Inpatient Psych PPS Wage Index. The Inpatient PPS FFY 2016 wage index was used to compute the Inpatient Psych PPS for FFY 2017.[3] For the discharges from October 1, 2016 through April 30, 2017, Provider's Inpatient Psych PPS payments were based on the FFY 2017 Inpatient Psych PPS Wage Index.[4]

Next, the Provider explained that Hardin's wage index data error occurred over a number of years, including the cost reports that went into the IPPS FFY 2015 wage index and the IPPS FFY 2016 wage index. The Provider asserts that the error occurred because Hardin was not correctly paid Part B physician salaries on Worksheet S-3, Part II.[5]

The Provider goes on to say that it has not and is not seeking a change to the wage index policy or regulation as part of this appeal. Instead, the Provider requests that the wage index reporting guidance be followed, which, according to the Provider, would require a correction to the Average Hourly Wage of the Elizabethtown-Fort Knox, KY CBSA. The Provider states that it believes that Hardin incorrectly reported its Worksheet S-3, Part II, Lines 5, 9 and 10, in violation of the cost report instructions, and the MAC did not catch this error in the cost report audit or the wage index audit.[6]

[2] 80 Fed. Reg. 46652, 46682 (Aug. 5, 2015).
[3] 81 Fed. Reg. 50502, 50509 (Aug. 1, 2016).
[4] Provider's Response to Board's RFI at 2 (December 2, 2021).
[5] *Id.* at 2-3.
[6] *Id.* at 3-4.

Last, the Provider acknowledges that there are facts in dispute, however these facts cannot be documented by the Provider because it does not have access to the necessary data. The Provider explains that it became aware of the understatement of the Elizabethtown-Fort Know wage index through its cost report preparer. The Provider contends that there is clearly a change in the way Hardin reported salaries on Worksheet S-3, Part II from FYE 6/30/2012 to FYE 6/30/2013, which suggests the possibility of a reporting error.[7] The Provider then concludes that, as it has provided documentation suggesting that Hardin's wage index reporting of physician salaries was not consistent:

> [T]he burden of proof now shifts to the MAC to show Provider and the Board Hardin's cost report workpapers and wage index workpapers, proving it audited Lines 5, 9, and 10 and found no issue with the reported amounts. It is not reasonable for the Provider to have this information.[8]

MAC's 12/31/2021 Response to Board's RFI

The MAC indicates that it does not "take issue" with the fiscal years and Federal Register provisions that the Provider identified as being at issue in this appeal. Additionally, the MAC does not "take issue" with the Provider's assertion that FYs 2015 and 2016 would be impacted by errors in Hardin's 2015 and 2016 cost reports.[9]

The MAC asserts that it does not appear that this appeal is appropriate for EJR, based on the Provider's explanation that it is not challenging the underlying policy regarding the calculation of the wage index.[10]

Issue under Dispute:

In this case, the Provider, a psychiatric hospital, is

> . . .[C]hallenging adjustments made by the Medicare Administrative Contractor ("MAC") for the following reasons: Upon review of the Medicare Wage Index for the Elizabethtown CBSA [core-based statistical area] (20160), it became apparent that the average hourly wage for the CBSA was aberrantly low. After examining the information reported by PPS providers physically located in this CBSA, errors in the data used to determine the Medicare Wage Index were identified. It is worth noting Hardin Memorial Hospital (Provider 18-0012) is the only PPS hospital contributing to the Wage Index for this CBSA, yet Hardin is reclassed to a different CBSA and does not use CBSA

[7] *Id.* at 5.
[8] Provider's Response to Board's RFI at 2 (Dec. 2, 2021).
[9] MAC's Response to Board's RFI at 1 (Dec. 30, 2021).
[10] *Id.* at 1-2.

> 20160. Provider requests redress of the MAC's failure to take notice of Hardin's extremely low average hourly wage and correct it to avoid an understatement of the entire CBSA's wage index.[11,12]

The Provider is seeking correction of what it believes are errors in Hardin Memorial Hospital's ("Hardin's") wage data used to determine the Wage Index and settle the Provider's April 30, 2017 cost report.[13] Significantly, the Provider is ***not*** challenging the Wage Index process or the rulemaking process (*i.e.*, there is no procedural challenge).[14]

Statutory and Regulatory Background:

A. Wage Index Applied to Short Term Acute Care Hospitals Subject to IPPS

The statute at 42 U.S.C. § 1395ww(d)(3)(E) specifies that, as part of the methodology for determining the prospective payment rates *applied to short term acute care hospitals*, the Secretary must adjust the standardized amounts[15] for area differences in hospital wage areas by a factor established by the Secretary reflecting the relative hospital wage level in a geographical area of the hospital compared to the national average hospital wage level. The Secretary defines

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[11] Provider's Preliminary Position Paper at 5.

[12] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientPsychFacilPPS/WageIndex (42 C.F.R. § 412.24 requires the Centers for Medicare & Medicaid Services ("CMS") to adjust the labor portion of the Federal per diem base rate to account for geographic differences in area wage levels using an appropriate wage index. CMS uses CBSA labor market area definitions and the prior year's pre-floor, pre-reclassified acute care hospital inpatient wage index to adjust inpatient psychiatric facility (IPF) payments. The application of the wage index is made on the basis of the location of the IPF.).

[13] Provider's EJR request at 1.

[14] In its December 2, 2021 response to the Board's RFI, the Provider states: "Throughout the pendency of this appeal, Provider has ***never*** sought a change to wage index policy or regulation. Rather, Provider simply requests the wage index reporting guidance be followed, which requires a correction to the AHWs of CBSA 21060 (Elizabethtown-Fort Knox, KY) as applied to Provider for the cost reporting period under appeal herein. There is only one provider (Hardin) in the Elizabethtown-Fort Knox, KY CBSA, and Hardin's wage index submission was incorrect for a number of years, including in the cost reports (FYEs 6/30/12 and 6/30/13) that formed the FFY 2015 and FFY 2016 IPPS wage index that was ultimately used for the Inpatient Psych PPS wage index for FFY 2016 and FFY 2017 for CBSA 21060 (Elizabethtown-Fort Knox, KY)."

[15] The statute, 42 U.S.C. § 1395ww(d)(2)(A), required the establishment of base-year cost data containing allowable operating costs per discharge of inpatient hospital services for each hospital. The base-year cost data were used in the initial development of the standardized amounts for PPS and they were used in computing the Federal rates. The standardized amounts are based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. § 1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994).

Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. Section 1395ww(d)(3)(E) requires that 62% of the standardized amount be adjusted by the wage index unless doing so would result in lower payments to a hospital than would otherwise be made. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

the various hospital labor market areas based on the delineations of statistical areas established by the Office of Management and Budget ("OMB").[16]

The statute at 42 U.S.C. § 1395ww(d)(3)(E) requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage-related costs of *short-term, acute care hospitals.*[17] Each hospital's data is collected on the Medicare Cost Report, Worksheet S-3.[18] The wage index is calculated and assigned to each hospital on the basis of the labor market area in which the hospital is located. Pursuant to 42 U.S.C. § 1395ww(d)(3)(E), the Secretary delineates hospital labor markets based on their OMB-established CBSAs.[19] The data collected for the IPPS wage index are also used to recalculate wage indexes applicable to other suppliers and providers such as home health agencies, skilled nursing facilities and hospices. In addition, they are used for prospective payments for inpatient rehabilitation facilities, inpatient psychiatric facilities ("IPF"), long-term care hospitals, and hospital outpatient services.[20]

The Secretary has developed a correction process for the wage index. The correction process is driven by the Hospital Wage Index Development Timetable[21] which sets dates for the release of wage index files and deadlines for hospitals to request revisions to cost report worksheets, occupational mix data and pension data prior to the MACs' desk reviews of the hospital's wage data. In January of a given calendar year, CMS releases public use files on its website containing urban and rural areas' average hourly wages and preliminary wage indexes. By mid-February, hospitals must request corrections to the wage data and desk review adjustment to wage index data. MACs must complete their review of this information by late March and notify the hospitals and CMS of final results of their reviews. CMS then permits hospitals to appeal the MAC determinations that had not been resolved earlier in the process. However, if a hospital does not request a MAC correction of its wage data, it is precluded from making an initial request from CMS at this point. The proposed IPPS rule is then published in in the Federal Register in April or May. Hospitals can seek correct of errors found in the proposed IPPS rule that were made by the MAC or CMS that could not be known prior to the publication of the proposed rule. The final IPPS rule is published in August.[22]

In the July 30, 1999 Final IPPS Rule for 2000, the Secretary announced that, while there was no formal appeals process that culminates before the publication of the final rule, hospitals may later seek formal review of denials of requests for wage data revisions made as a result of the wage data correction process. She pointed out that, as noted in the September 1, 1995 Federal Register,[23] hospitals are entitled to appeal any denial of a request for a wage data revision, made as a result of the agency's wage data correction process, to the Board consistent with the rules for Board appeals. Further, the Secretary noted that the September 1, 1995 Federal Register stated

[16] 81 Fed. Reg. 56,762, 56,912 (Aug. 22, 2016).
[17] (emphasis added).
[18] 81 Fed. Reg. at 56912.
[19] *Id.* at 56913.
[20] *Id.* at 56914.
[21] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FY2017-WI-Time-Table.pdf (last visited Jan. 28, 2020).
[22] *See generally* 81 Fed. Reg. at 56932-33.
[23] *See* 60 Fed. Reg. 45778, 45792-45903.

that any subsequent reversal of a denial of a wage revision request that results from a hospital's appeal to the Board or beyond, will be given effect by paying the hospital under a revised wage index reflecting the revised wage data at issue.[24]

More recently in the 2017 Final IPPS Rule, the Secretary reiterated that the processes previously described had been created to resolve all substantive wage index data correction disputes before the finalized wage and occupational mix data for the FY 2017 payment rates were published. The Secretary emphasized that hospitals that did not meet the procedural deadlines set forth above would not be afforded a later opportunity to submit wage index data corrections or to dispute the MAC's decision with respect to requested changes. Specifically, this policy makes clear that hospitals not complying with the procedural deadlines set forth above will not be permitted to later challenge CMS' failure to make a requested data revision before the Board.[25]

The Secretary further stated that, because hospitals had access to the final wage index data public use files by late April 2016, they had the opportunity to detect any data entry or tabulation errors made by the MAC or CMS before the development and publication of the final FY 2017 wage index by August 2016, and the implementation of the FY 2017 wage index on October 1, 2016. Given these processes, the Secretary believes that the wage index implemented on October 1, 2016 should be accurate. Nevertheless, in the event that errors are identified by hospitals and brought to CMS' attention after May 23, 2016, the Secretary retained the right to make midyear changes to the wage index under very limited circumstances. Specifically, in accordance with 42 C.F.R. § 412.64(k)(1), the Secretary can make midyear corrections to the wage index for an area only if a hospital can show that: (1) the MAC or CMS made an error in tabulating its data; and (2) the requesting hospital could not have known about the error or did not have an opportunity to correct the error, before the beginning of the fiscal year. For purposes of this provision, "before the beginning of the fiscal year" means by the May deadline for making corrections to the wage data for the following fiscal year's wage index (for example, May 23, 2016 for the FY 2017 wage index). ***The Secretary cautioned that this provision is not available to a hospital seeking to revise another hospital's data that may be affecting the requesting hospital's wage index for the labor market area***.[26]

B. Wage Index Applied to Psychiatric Hospitals Subject to the IPF PPS

Section 124 of the Balanced Budget Refinement Act of 1999 ("BBRA") mandated that the Secretary develop a per diem PPS for inpatient hospital services furnished in psychiatric hospitals and psychiatric units.[27] The Secretary implemented the IPF PPS in the final rule published on November 15, 2004 and specifically included a wage index adjustment among the policies and methodologies for IPF PPS.[28]

The Secretary proposed to use the unadjusted, pre-reclassified hospital wage index to account for geographic differences in labor costs. In the proposed rule, the Secretary proposed to use the

[24] 64 Fed. Reg. 41490, 41513 (July 20, 1999).
[25] 81 Fed. Reg. 56762, 56933 (Aug. 22, 2016).
[26] *Id*.
[27] Pub. L. No. 106-113, AppendixF, 113 Stat. 1501A-321, 1501A–332 (1999).
[28] 69 Fed. Reg. 66922 (Nov. 15, 2004).

inpatient acute care hospital wage data to compute the IPF wage index since there was not an IPF specific wage index available. The Secretary observed that, since IPFs generally compete in the same labor market as acute care hospitals, the inpatient acute care hospital wage data should be reflective of labor costs of IPFs. He believed this to be the best available data to use as a proxy for an IPF specific wage index. He explained that the actual location of the IPF as opposed to the location of affiliated providers was most appropriate for determining the wage adjustment because the data supported the premise that the prevailing wages in the area in which the IPF is located influence the cost of a case. Thus, the Secretary decided to use the inpatient acute care hospital wage data without regard to any approved geographic reclassification.[29]

In the final rule, the Secretary stated that the FY 2005 hospital wage index (unadjusted and unreclassified) based on MSA definitions defined by OMB in 1993 (as opposed to the new MSA definitions that were used to define labor markets for the FY 2005 IPPS) would be used determine the IPF specific wage index. Once the IPF PPS was implemented, the Secretary would assess the implications of the new MSA definitions on IPFs. At the time of the proposed rule, the 2003 MSA definition had not been implemented for any Medicare programs and, consequently, were not proposed. The Secretary noted that, after the publication of the IPF PPS proposed rule, new MSA definitions were adopted for use in the IPPS. However, the Secretary did not adopt those new definitions in the 2005 IPF final rule.[30]

In the Rate Year ("RY") 2007 IPF PPS Final Rule,[31] the Secretary adopted the new statistical area CBSA-based labor market area definitions for IPF PPS.[32] At the time, CBSAs were OMB's latest Metropolitan Area definitions based on the 2000 census because the Secretary felt that these Metropolitan Area designations more accurately reflected the local economics and wage levels of the areas in which hospitals were currently located. The Secretary explained that the IPF PPS wage index adjustment was intended to reflect the relative hospital wage levels in the geographical area of the hospital as compared to the national average hospital wage level. The IPF PPS uses the acute care inpatient hospitals' wage data in calculating the IPF PPS wage index. However, *unlike IPPS*, IPF PPS uses the pre-floor, pre-reclassified hospital wage index. In addition, with the adoption of the new CBSA-based designations, the Secretary continued to have two types of labor market areas: urban and rural.[33] Because the majority of IPFs were not significantly impacted by the new labor market areas, no transition payment to the new CBSA-based labor market areas for the purpose of IPF PPS was created.[34]

Provider's Position

In its response to the Board's RFI, the Provider stated that it has not and is not seeking a change to the wage index policy or regulation as part of this appeal. Instead, the Provider requests that the wage index reporting guidance be followed, which, according to the Provider, would require

[29] *Id.* at 66952.
[30] *Id.*
[31] 71 Fed. Reg. 27040 (May 9, 2006).
[32] *Id.* at 27601.
[33] *Id.* at 27602.
[34] *Id.* at 27605.

a correction to the Average Hourly Wage of the Elizabethtown-Fort Knox, KY CBSA.[35] In its appeal request the Provider explains:

> More specifically, Hardin Memorial Hospital had reported salaried physician part B information for excluded areas on both Wage Index line 5 and then again on the excluded area lines 9 & 10 of Worksheet S-3 part II. There was also an improper allocation of Wage Related Costs resulting from the double counting of Physician Part B salaries. This error in the reporting of the part B physician salaries and benefits has resulted in a significant understatement of the average hourly wage (AHW) for both Hardin Memorial Hospital and the Elizabethtown CBSA.
>
> Consequently, the wage index factor derived from this AHW and the corresponding Wage Index information was significantly understated. The erroneous reporting caused an understatement of the Wage Index factor for the Elizabethtown CBSA.
>
> The understated Wage Index factor of the Elizabethtown CBSA directly influenced the PPS payments made to Lincoln Trail.
>
> In order to calculate the accurate Wage Index factor, in 2017 the following items were addressed on Hardin Memorial Hospital's Wage Index schedule:
>
> - Part B physician salaries have been adjusted for proper reporting. Excluded area physicians are now reported only on the excluded area line.
> - Wage related costs were reallocated based on the adjustments made to S-3, part II lines 5, 9 and 11.
>
> The revised AHW was then used to determine a more accurate wage index factor for the Elizabethtown CBSA, effective with the FFY 2019 Wage Index for the CBSA 20160. The wage index factor for CBSA 20160 has risen once the CBSA was correctly reported beginning with FFY 2019.[36]

The Provider makes the same arguments in its EJR request and explains that it believes that CMS' inclusion of a provider's aberrant data violates the Secretary's obligation to create a uniform wage index, and "the Board is bound by CMS policy until the Secretary instructs the Board otherwise."[37]

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[35] Provider's Response to Board's RFI (Dec. 2, 2021).
[36] Provider Appeal Request, Issue Statement.
[37] EJR Request at 6 (Jan. 7, 2020).

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) (2019), 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. Board's Previous Jurisdiction and Substantive Claim Findings

On September 1, 2021, the Board issued a letter in which it, in part, found that it had jurisdiction over the sole issue in this appeal. The Board stated:

> The Board finds that the appeal was timely filed and the $10,000 threshold for Board jurisdiction has been met. With regard to the wage index issue, the Board reviewed the controlling statute for the IPF PPS at 42 U.S.C. § 1395ww(s); the IPF regulations at 42 C.F.R. §§ 412.428-412.432; and the Federal Register notices regarding IPF PPS payments. The Board did not identify any bar for an IPF from appealing the wage index issue. Accordingly, the Board concludes that there is no bar to IPF appeals of this issue and that the Board has jurisdiction over this appeal.[38]

In the same letter, the Board issued preliminary findings on the substantive claim challenge and found that Lincoln Trail failed to specifically include a substantive claim for the wage index AHW issue under appeal as required under 42 C.F.R. § 413.424(j)(1).[39]

B. Board's Decision Regarding EJR

Based on the record before it, including the responses to the Board's Requests for Information, and the Board questions, the Board finds that, pursuant to 42 C.F.R. § 405.1842(f)(2)(iii), there are material facts that remain in dispute and there is insufficient information in the record to determine whether granting the Provider's EJR request is appropriate. Specifically, § 405.1842(f) states:

> (f) *Board's decision on EJR: Criteria for granting EJR.* Subject to paragraph (h)(3) of this section, the Board is required to issue an EJR decision following either the completion of the Board's own motion consideration under paragraph (c) of this section, or a

[38] Board Ruling on Jurisdiction & Substantive Claim Challenge and Notice of Own Motion EJR Relative to 42 C.F.R. §§ 413.24(j) and 405.1873 (Sept. 1, 2021).
[39] *See supra note* 1. The Board notes that it also issued Notice of Own Motion EJR Relative to the Provider's response to the MAC's Substantive Claim Challenge, in which the Provider questions the procedural and substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873.

> notice issued by the Board in accordance with paragraph (e)(3)(i) of this section.
>
> (1) The Board's decision must grant EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines the following conditions are satisfied:
>
> (i) The Board has jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.
>
> (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.
>
> (2) **The Board's decision must deny EJR** for a legal question relevant to a specific matter at issue in a Board appeal **if** any of the following conditions are satisfied:
>
> (i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue in accordance with § 405.1840 of this subpart.
>
> (ii) The Board determines it has the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is neither a challenge to the constitutionality of a provision of a statute, nor a challenge to the substantive or procedural validity of a regulation or CMS Ruling.
>
> (iii) T**he Board does not have sufficient information to determine whether the criteria specified in paragraph (f)(1)(i) or (f)(1)(ii) of this section are me**t.

The case revolves around the Elizabethtown CBSA which is based on a single hospital – Hardin. The Board finds that the record is not sufficiently developed to be able to determine whether EJR is appropriate *or needed*. The Provider's legal question is dependent upon certain facts being true, namely that Hardin's wage data for the years in question contained certain material errors and that those errors were not corrected as part of the wage index audit for those years. The Provider has summarily asserted that its burden of proof to establish these material facts has shifted to the MAC:

> The Provider does acknowledge **there are factual issues in dispute**; however, historically the Board has been unwilling relieve the moving Provider of its regulatory burden of proof to the party with access to the relevant information, which is more of a question of law. **Here, the factual issues cannot be documented**

> **by the Provider because it does not have access to the necessary data**.
>
> . . . . The Provider acknowledges it is difficult to prove errors made by another hospital to which it has no connection except co-location within the same CBSA. Provider became aware of the understatement of the Elizabethtown-Fort Knox wage index **through its cost report preparer**. The table in Section II was prepared by the Provider's cost report preparer. **Provider can see from the subscription service** that there is clearly a change in the way Hardin reports salaries on Worksheet S-3, Part II from FYE 6/30/12 to FYE 6/30/13, which suggests the possibility of a reporting error. Exhibit P-1 shows both the submitted and settled cost reports for FYE 6/30/12. Hardin reports nothing in Line 5, but has sizeable reporting in Lines 9 and 10. Exhibit P-2 shows both the submitted and settled cost reports for FYE 6/30/13. There, Hardin all of the sudden reports nearly $3M in Line 5 and reports an increase in Line 10 that is $3.3M greater than what it reported in the prior year. Yet, that significant reporting change was seemingly not noticed by the MAC in its two occasions to review the information.
>
> The PRRB's decision must be supported by substantial evidence. *Pomona Valley Hospital Medical Center v. Azar*, 1:18-cv-02763-ABJ, 2020 WL 5816486 (Sept. 30, 2020). However, the burden of proof transfers to the MAC **when it is in sole possession of key data**. *Id. See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20, 51-52 (D.D.C. 2008): "[W]here **an agency** is in sole possession of the records necessary to prove a party's claim, the agency may not reject the aggrieved party's allegations as insufficiently proven unless the agency comes forward with countervailing evidence or a reason, *not based on the insufficiency of the [movant's] showing*, that explains why the . . . allegations have not been accepted." **As the Provider has provided documentation suggesting Hardin's wage index reporting of physician salaries was not consistent, the burden of proof now shifts to the MAC to show Provider and the Board Hardin's cost report workpapers and wage index workpapers, proving it audited Lines 5, 9, and 10 and found no issue with the reported amounts. It is not reasonable for the Provider to have this information. Courts have supported this shifting of the burden of proof to the MAC.**

At the outset, it is important to recognize that the regulations governing proceedings before the Board allow for a discovery process and this discovery process applies to parties to the Board appeal as well as to nonparties except for CMS, HHS, or another federal agency. Specifically, 42 C.F.R. § 405.1853(e) states in relevant part:

> (e) *Discovery*—(1) *General rules*. (i) Discovery is limited in Board proceedings.
>
> (ii) The Board may permit discovery of a **matter that is relevant to the specific subject matter of the Board hearing**, **provided the matter is not privileged or otherwise protected from disclosure and the discovery request is not unreasonable, unduly burdensome or expensive, or otherwise inappropriate**.
>
> (iii) Any discovery initiated by a party must comply with all requirements and limitations of this section, and with any further requirements or limitations ordered by the Board.
>
> (iv) The applicable provisions of the Federal Rules of Civil Procedure and Rules 401 and 501 of the Federal Rules of Evidence serve as guidance for any discovery that is permitted under this section or by Board order.
>
> (2) Limitations on discovery. Any discovery before the Board is limited as follows:
>
> (i) **A party may request of another party, or of a nonparty other than CMS, the Secretary or any Federal agency**, the reasonable production of documents for inspection and copying.
>
> (ii) A party may also request another party to respond to a reasonable number of written interrogatories.

Contrary to the Provider's assertion, the MAC is not "the Agency" (*i.e.*, CMS) and, unlike CMS, the MAC is a party to this hearing and *is subject to the above discovery process*.[40] Notwithstanding, the Provider apparently has not served any discovery on the MAC. Moreover, it is unclear to what extent the MAC may possess all of the relevant information and documentation. The documents at Exhibit P-1 and P-2 that the Provider obtained from its "subscription service" suggest that the MAC may have "settled without audit" the wage data for the years at issue. As a result, is unclear to what extent the MAC audited the specific aspects of the wage data at issue that the Provider alleges contains errors.

Indeed, it is clear that the MAC is not in ***sole*** possession of the relevant information and documents. Here, Hardin clearly possesses key information and documents such as the relevant as-filed and audited cost reports and supporting workpapers. Similarly, it is also clear that the Provider has had access to certain relevant documents and information through its cost report preparer as well as the "subscription service" that it referenced in its December 2, 2021 filing.

[40] Accordingly, the Provider's reliance on the *Baystate* and *Palomar* decisions is misplaced as those cases involved situations where the relevant data was in sole possession of the Agency (*i.e.*, CMS).

However, the Provider has not explained to what extent the Provider has contacted Hardin (including conducting discovery permitted from nonparties under § 405.1853(e)) or to what extent it exhausted information available through the sources it has used, namely its cost report preparer and "subscription service."

Based on the above findings, the Board concludes that there are material factual disputes and that the Provider has failed to establish that the information and documents necessary to resolve those disputes are not available through the discovery process available at § 405.1853(e). As there are material factual disputes that must be resolved before the Board can reach the legal question posed in the EJR request, the Board is not yet able to determine whether it lacks the authority to decide a specific legal question *relevant to the specific matter at issue*, as required to grant EJR pursuant to 42 C.F.R. § 405.1842(f)(1)(ii). Indeed, the Board would be able to resolve this appeal if the Board were to find that the alleged Hardin errors did not exist.[41]

Accordingly, pursuant to 42 C.F.R. § 405.1842(f)(2)(iii), the Board hereby **denies** the Provider's EJR request. This case remains open and the Providers may re-file the EJR request, as appropriate, following further development of the record.[42]

Board Members Participating:

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

FOR THE BOARD:

1/26/2022

X Clayton J. Nix

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

cc: Judith Cummings, CGS
Wilson Leong, FSS

[41] In finding that consideration of a request for EJR in this matter is not ripe, the Board notes that 42 C.F.R. § 405.1837(e)(3)(ii) is not applicable because the Board is presented with more than simply an "incomplete [EJR] request." Here, the Board is presented with unresolved factual disputes about Hardin that are material to determining whether EJR is appropriate and relevant. The legal challenge to the IPF IPPS wage index assigned to the Elizabethtown CBSA for the years at issue becomes relevant *only if* certain allegations about Hardin (as made by the Provider) are true. In other words, if Hardin had no errors in its wage index data for the relevant years at issue, then there would be no error in the wage index assigned to the Elizabethtown CBSA as used in the IPF IPPS rates at issue and, accordingly, the Board would then have the authority to resolve the dispute as there would be no basis for the EJR request *as currently stated*. *See supra* note 14 and accompanying text (quoting the Provider's response to the Board's RFI).

[42] *See* 42 C.F.R. § 405.1837(g)(3), (h)(2); 42 C.F.R. § 405.1873(f) (confirming that there is no final EJR decision). *See also supra* note 1.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
Gadsden Regional Medical Center (Prov. No. 01-0040)
FYE 9/30/2012
Case No. 16-0101

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. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On October 20, 2015, the Board received Provider's Individual Appeal Request appealing their April 21, 2015 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2012. The initial appeal contained these two issues:

1. DSH/SSI (Provider Specific)
2. DSH Payment- Medicaid Eligible Days

On January 11, 2022, the Provider withdrew the DSH Payment – Medicaid Eligible Days issue from the appeal.

The only remaining issue in this appeal is the DSH/SSI (Provider Specific) issue. In its appeal request, the Provider summarizes Issue 1, the DSH/SSI (Provider Specific) issue, as follows:

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[1]

The Provider has not filed a Final Position Paper in this appeal.

On September 11, 2015, the Provider filed a Model Form E, Request to Join Existing Group Appeal: Direct Appeal From Final Determination, in Case No. 14-3046GC entitled "Community Health Systems Post 1498-R 2012 DSH SSI Data Match CIRP Group." The Final Determination referenced on the Model Form E is the Provider's April 21, 2015 Notice of Program Reimbursement. The Provider describes the group issue under appeal in Case No. 14-3046GC as follows:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation ... The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes…
>
> Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(5)(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610. 15, or any other applicable statutes, regulations, program guidelines, or case **law.**

[1] Individual Appeal Request, Issue 1.

> On March 22, 2006, the Provider Reimbursement Review Board (PRRB) issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the reporting of SSI days; 2) the PRRB has the authority to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.
>
> The PRRB's decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.
>
> CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS,which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that such Dually Eligible/Crossover days, including such days that are Medicare Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert thatall such days are not properly being captured in the Medicare proxy of the DSH…[2]

On May 25, 2018, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor in this appeal which argued that the Board lacks jurisdiction over Issue 1, the DSH/SSI (Provider Specific) issue, because the portion of the issue concerning SSI data accuracy is duplicative of the group appeal issue in CN 14-3046GC and this Provider was directly added to Case No. 14-3046GC. The Medicare Contractor asserts that duplicative issues in separate appeals are prohibited by PRRB Rule 4.5[3]

[2] CN 14-3046GC, Group Appeal Request, Tab 2.
[3] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (May 22, 2018).

Board Decision:

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

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Data Match issue that was directly added to Group Case No. 14-3046GC.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI Data Match issue) that was directly added to Case No. 14-3046GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[4] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[5] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[6] The DSH/SSI Data Match issue in group Case No. 14-3046GC similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the appealed issue in group Case No. 14-3046GC. Because the issue is duplicative, and duplicative issues

[4] Individual Appeal Request, Issue 1.
[5] *Id.*
[6] *Id.*

appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 14-3046GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[7] Provider is in error in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" data match issue appealed in Case No. 14-3046GC.

Accordingly, the Board must find that Issue 1, and the DSH/SSI Percentage Data Match issue directly added to Group Case No. 14-3046GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 …" The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Additionally, the Provider's Fiscal Year End is the same as the Federal fiscal year end, and the request for realignment is illogical. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. As this is the only issue in Case No. 16-0101, the appeal is now closed.

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

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

Board Members Participating:

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For the Board:

1/27/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdictional Decision***
QRS BSWH 2015 DSH Uncompensated Care Distribution Pool CIRP Group
Case No. 18-1282GC

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced common issue related party ("CIRP") group appeal. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The issue being appealed is a challenge to the Disproportionate Share Hospital ("DSH") payment for uncompensated care costs ("UCC"), which argues that CMS acted beyond its authority and otherwise arbitrarily and capriciously in its calculation of the size of the pool of the UCC payments available for distribution to DSH eligible hospitals, specifically, in its calculation of Factors 1 and 2.[1] First, the Providers claim that CMS acted beyond its authority by violating the notice and comment rulemaking requirements of the Administrative Procedure Act ("APA"). They say that providers had a lack of information during the initial rulemaking for rules regarding UCC payments, and as a result could not submit meaningful commentary on the proposed rules.[2] Second, the Providers state that CMS acted beyond its authority by failing to adhere to the *Allina*[3] decision. They argue that the base year statistic used to calculate the 2014 UCC payments (2011) was understated due to mistreatment of Part C days, and claim that *Allina* required a recalculation of the 2011 data since that case rendered CMS' policy regarding those days "null and void."[4]

[1] Group Issue Statement at 1.
[2] *Id.* at 1-2.
[3] *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1111 (D.C. Cir. 2014).
[4] Group Issue Statement at 3.

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[5]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[6] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[7] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[8] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they

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[5] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[6] 830 F.3d 515 (D.C. Cir. 2016).
[7] 89 F. Supp. 3d 121 (D.D.C. 2015).
[8] 830 F.3d 515, 517.

are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[9]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[10]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[11] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[12] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[13]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[14] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[15] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[16] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a

[9] *Id.* at 519.
[10] *Id.* at 521-22.
[11] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[12] *Id.* at 506.
[13] *Id.* at 507.
[14] 514 F. Supp. 249 (D.D.C. 2021).
[15] *Id.* at 255-56.
[16] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).

subsequent cost report that was a full twelve months.[17] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[18]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[19]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[20] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[21] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[22]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which

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[17] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[18] *Id.*
[19] *Id.* at 262-64.
[20] *Id.* at 265.
[21] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[22] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

requires a violation of a clear statutory command.[23] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[24] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[25] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[26] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[27] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[28]

Board Decision:

The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2015. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

Accordingly, the Board dismisses Case No. 18-1282GC and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42

[23] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[24] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[25] *Id.* at *4.
[26] *Id.* at *9.
[27] 139 S. Ct. 1804 (2019).
[28] *Ascension* at *8 (bold italics emphasis added).

U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[29] Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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For the Board:

1/28/2022

X Clayton J. Nix

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

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

[29] 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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Ms. Stephanie Webster, Esq.
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RE: ***Jurisdictional Decision***
Southern Regional Medical Center (Prov. No. 11-0165)
FYE 6/30/2010
Case No. 14-2731

Dear Ms. Webster,

This case involves the Provider's appeal of its Medicare reimbursement for the fiscal year ending ("FYE") in 2010. On its own motion, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Provider's documentation in response to the 2018 decision of the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") in *Mercy Hospital, Inc. v. Azar* ("*Mercy*").[1] Following review of the documentation, the Board finds that it does not have jurisdiction to hear the Provider's Inpatient Rehab Facilities – Low Income Payment ("IRF-LIP") reimbursement issue and dismisses it from the instant appeal.

Pertinent Facts:

Southern Regional Medical Center ("Provider ") is represented in this case by Ropes & Gray, LLP. The Board received Provider's Request for Hearing on March 4, 2014, appealing from a Notice of Program Reimbursement ("NPR") dated September 6, 2013. The appeal request contained the four (4) following issues:

1. Calculation of DSH Medicare Part A/SSI Fraction Numerator,
2. Medicare Advantage Days,
3. Bad Debts, and
4. Rehabilitation Facility Low-Income Percentage Adjustment

The last issue described four distinct grievances related to the LIP adjustment:

a. Medicaid Eligible LIP
b. Part C LIP
c. Non-Covered Days LIP
d. SSI Fraction Understatement

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

On October 15, 2014, the Provider requested a transfer of Issue 2 (Medicare Advantage Days) to two separate group cases, thus bifurcating the issue into Part C Days (SSI Fraction) and Part C Days (Medicaid Fraction). The same day, the Provider also requested a transfer of Issue 1 to a group case.

On February 11, 2015[2], the Provider withdrew one portion of Issue 4, namely the "Medicaid eligible days component of the rehabilitation facility [LIP] adjustment issue[.]" It noted, however, that it was ***not*** withdrawing other components of Issue 4, such as the SSI Fraction and Part C days treatment in the LIP calculation.

Applicable Regulatory Provisions and Board Rules:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840 (2010), a provider has a right to a Board hearing with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more ($50,000 for a group), and the request for hearing is filed within 180 days of the date of receipt of the final determination. Under 42 C.F.R. § 405.1835(a)(1) (2010), a provider has preserved its right to claim dissatisfaction with the amount of Medicare payment for a specific item at issue by either (i) including a claim for the specific item on its cost report for the period where the provider seeks payment that it believes to be in accordance with Medicare policy; or (ii) effective with cost reporting periods that end on or after December 31, 2008, self-disallowing the specific item by following the applicable procedures for filing a cost report under protest where the provider seeks payment that it believes may not be in accordance with Medicare policy.

Board Review of the LIP Adjustment Issue is Precluded by Statute:

The Provider's Issue 4 "concerns the Medicare Administrative Contractor's ('MAC') improper determination of the Provider's low income percentage adjustment ('LIP adjustment') under the prospective payment system for inpatient rehabilitation services." The first component of the LIP adjustment the Provider appealed was the exclusion of patient days that were eligible for medical assistance but not included in the MAC's final determination. This component of the LIP adjustment issue was withdrawn on February 11, 2015.

The second component of the LIP adjustment appealed was the treatment of Medicare Part C days in the calculation of the adjustment. The Provider says the rule on Part C days is procedurally invalid because CMS did not comply with notice and comment rulemaking requirements (citing *Allina*). Third, the Provider argues that the MAC improperly treated non-covered days in calculating the LIP adjustment, and that days were improperly excluded from the numerator of the Medicaid Fraction. Finally, the Provider contends that its SSI fraction is understated, and that the Provider has no way to determine whether its recalculated SSI fraction is actually correct in light of *Baystate*.

[2] Withdraw letter dated February 10, 2015, received February 11, 2015.

The Provider concludes its issue statement for the LIP adjustment issues with a Jurisdictional Statement. It argues that review of the calculation of the LIP adjustment is not precluded from review by 42 U.S.C. § 1395ww(j)(8) or 42 C.F.R. § 412.630. It argues that these authorities do not preclude the review of the LIP adjustment to the base Federal prospective payment rate, but simply preclude review of enumerated unadjusted base rates within the prospective payment system.

Under 42 U.S.C. § 1395ww(j)(8)(B), Congress specifically precludes administrative or judicial review of the prospective payment rates ("PPS") for inpatient rehabilitation facilities ("IRFs"). Although providers have attempted to dispute exactly what rate-setting "steps" Congress intended to shield from review under the statute, the D.C. Circuit's decision in *Mercy* answers this question and clarifies what is shielded from review in its analysis of this issue.[3]

In *Mercy*, the D.C. Circuit describes CMS' two-step rate-setting process for Medicare reimbursement for IRFs. The first step takes place prior to the beginning of the fiscal year and involves CMS' establishment of a standardized reimbursement rate, while the second step involves CMS' adjustments (calculated by the Medicare contractor) to "the standardized rates to reflect the particular circumstances of each hospital for that year." One of the ways in which CMS adjusts a hospital's IRF Medicare payment is by taking into account the number of low income patients ("LIP") served by the hospital, also known as the LIP adjustment. The D.C. Circuit in *Mercy* affirmed the District Court, wherein the District Court concluded that 42 U.S.C. § 1395ww(j)(8) prohibits administrative or judicial review of the Medicare Contractor's determination of the LIP adjustment, because such review amounts to review of the establishment of the hospital's prospective payment rates.[4] The D.C. Circuit concluded that the Statute's plain language prohibits administrative and judicial review of not only the statutory adjustments, but also the "step two rates" utilized by the Medicare Contractor when adjusting the standardized reimbursement rate and then calculating a hospital's final payment.[5]

In the instant appeal, the Provider seeks Board review of several components utilized by the Medicare Contractor to determine the Provider's LIP adjustment, namely its SSI Ratio and the treatment of other categories of days as they specifically relate to the LIP adjustment. As Congress has prohibited administrative and judicial review of the prospective payment rates for IRFs, including the LIP adjustment, the Board lacks the jurisdiction to hear the Provider's appeal of the LIP adjustment and dismisses the issue in the instant appeal. In making this finding, the Board notes that the D.C. Circuit's decision in *Mercy* is controlling precedent because the Providers could bring suit in the D.C. Circuit.[6]

---

[3] *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062 (D.C. Cir. 2018).
[4] *Mercy Hosp., Inc. v. Burwell*, 206 F.Supp.3d 93, 102-103 (D.D.C. 2016).
[5] *Mercy*, 891 F.3d at 1068.
[6] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35

Conclusion:

The Board hereby dismisses Issue 4, the LIP adjustment issue and all of its remaining subcomponents (Part C Days, SSI accuracy and Part A Days/SSI Fraction) *in its entirety*, from this appeal.

As a result, the bad debt issue is the sole issue remaining in this appeal and Case No. 14-2731 remains open. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the case.

Board Members Participating:

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

For the Board:

1/31/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Cecile Huggins, Palmetto GBA

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Jurisdictional Decision***
Indian River Memorial Hospital (10-0105)
FYE 9/30/2008
Case No. 14-1445

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. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On December 19, 2013, the Board received the Provider's Individual Appeal Request appealing their June 26, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2008. The initial appeal contained the eight (8) following issues:

1. DSH/SSI Percentage (Provider Specific)
2. DSH/SSI (Systemic Errors)
3. DSH Payment – Medicaid Eligible Days
4. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
5. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days
6. DSH Payment – SSI Fraction/Dual Eligible Days
7. DSH Payment – Medicaid Fraction/Dual Eligible Days
8. Outlier Payments – Fixed Loss Threshold

On August 14, 2014, Issues 2, 4, 5, 6, 7, and 8 were transferred to group appeals. On August 28, 2014, the Provider withdrew Issue 3. The only remaining issue is Issue 1- DSH/SSI Percentage (Provider Specific).

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C.

> §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[1]

Provider described its DSH/SSI Percentage issue, which has been transferred to a Case Number 13-2694G, as follows:

> The Providers contend that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Providers further contend that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Reports does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Paid days vs. Eligible Days
> 3. Not in agreement with provider's records
> 4. Fundamental problems in the SSI percentage calculation
> 5. Covered days vs. Total days and
> 6. Failure to adhere to required notice and comment rulemaking procedures.[2]

[1] Individual Appeal Request, Issue 1.
[2] *Id.* at Issue 2.

Board Decision:

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

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 13-2694G.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 13-2694G. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[3] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[4] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[5] Issue 2, transferred to group Case No. 13-2694G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 which was transferred to Case No. 13-2694G. Because the issue is duplicative, and duplicative issues

[3] Individual Appeal Request, Issue 1.
[4] *Id.*
[5] *Id.*

appealed from the same final determination are prohibited by Board Rule 4.5 (2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 13-2694G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[6] Provider is in error in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 13-2694G.

Accordingly, the Board must find that Issues 1 and the DSH/SSI Systemic Errors issue, which was transferred to Group Case No. 13-2694G, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2013), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. 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 . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Additionally, the Provider's Fiscal Year End is the same as the Federal fiscal year end, and the request for realignment is illogical. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Since this is the last issue in the appeal, Case No. 14-1445 will be closed and removed from the Board's docket.

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

---

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

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1/31/2022

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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Northwestern Memorial Hospital (Prov. No. 14-0281)
FYE 8/31/2015
Case No. 22-0450

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' January 18, 2022 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[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] Providers' EJR request 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).

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.

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 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

[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).

> 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. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before

[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).

> 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:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus

[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 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]

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]

---

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

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 is requesting the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the DGME cap on full-time equivalent ("FTE") residents and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[17] The Provider explains that it is a teaching hospitals that receive DGME payments, and that during the cost year in dispute, its unweighted FTE count exceeded it FTE cap. It also trained fellows and other residents who were beyond their initial residency period ("IRP").[18]

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[19] Instead, a weighted FTE cap is determined 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,[20] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Provider contends that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[21]

Second, the Provider argues, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Provider explains that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.

Third, in some situations, as demonstrated by the Table on page 11 of the Provider's EJR Request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Provider concludes that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since the Board lacks the authority to grant the relief sought, the Provider requests that EJR be granted.

---

[17] Provider's Petition for Expedited Judicial Review at 1 (Nov. 23, 2021) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[18] *Id.* at 8.
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[21] *Id.* at § 1395(h)(4)(F)(i).

The Medicare Contractor has not filed a response to the EJR Request and the time for doing so has elapsed.[22]

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) (2019), 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. Compliance with requirements for filing a Board appeal

The Provider in this case filed from the failure to issue a timely final determination. The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board 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 (as determined in accordance with paragraph (c)(1) of this section) . . .[23]

In this case, the Provider filed a timely appeal. Its amount in controversy also exceeds the $10,000 threshold. The Provider also filed an appeal of the DGME issue before the 12 month period after the date of the receipt of the cost report by the Medicare Contractor.

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

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

[22] PRRB Rule 42.4 (2021).
[23] (emphasis added).

Association v. Bowen ("*Bethesda*").[24] 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.[25]

On August 21, 2008, new regulations governing the Board were effective.[26] 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*").[27] 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.[28]

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

The Board has determined that the Provider in Case No. 22-0450 involved with the instant EJR request involves a cost report period which began ***prior to*** January 1, 2016 and is governed by CMS Ruling CMS-1727-R. In addition, the Provider's jurisdictional documentation shows that the estimated amount in controversy exceeds $10,000, as required for an individual appeal.[29] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying provider. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[24] 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.).
[25] *Bethesda*, 108 S. Ct. at 1258-59.
[26] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[27] 201 F. Supp. 3d 131 (D.D.C. 2016).
[28] *Id.* at 142.
[29] *See* 42 C.F.R. § 405.1839.

C. 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 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 formula 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 primary care and obstetrics and gynecology residents and separately for nonprimary care residents:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}\,^{30}$$

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.[31] 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.[32] 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

[30] EJR Request at 4.
[31] *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.)).
[32] 66 Fed. Reg. at 39894 (emphasis added).

> 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].[33]

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.[34] 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."[35] 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[36] (*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.[37]

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

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[33] (Emphasis added.)
[34] *See* 62 Fed. Reg. at 46005 (emphasis added).
[35] *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.)).
[36] 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.
[37] 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.

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 Providers are 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 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 year and that the Provider in this appeal is entitled to a hearing before the Board;

2) Based upon the Provider'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)(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 the case, the Board hereby closes the case. The Board's jurisdictional

determination is subject to review 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.
Robert A. Evarts, Esq.
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Ratina Kelly, CPA

FOR THE BOARD:

1/31/2022

X Clayton J. Nix

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

cc: Pamela VanArsdale, National Government Services, Inc.
Wilson Leong, FSS