DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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Pamela VanArsdale, Appeals Lead
National Government Services, Inc. (J-6)
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RE: ***Board Determination on CIRP Group That Does Not Meet Jurisdictional Threshold***
Mercyhealth CY's 2015 - 2017 SSI Calculation Error CIRP Group
Case No. 21-1345GC

Dear Mr. Gienko and Ms. VanArsdale:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal which was filed by Strategic Reimbursement Group, LLC ("Strategic" or "Representative"). The CIRP group, filed under the Mercyhealth parent organization, includes two Providers appealing three calendar years ("CY's") but, does not meet the required $50,000 jurisdictional threshold. The pertinent facts related to the group case and the Board's determination are set forth below.

Pertinent Facts:

On June 7, 2021 Strategic filed the Mercyhealth SSI Calculation CIRP Group for CY 2017. On the same date Strategic transferred Rockford Memorial Hospital (Prov. No. 14-0239/"Rockford") for FYE 06/30/2017 to the group, Case No. 21-1345GC, from its individual appeal, Case No. 21-0220.

On September 15, 2021, the Board issued a Request for Information ("RFI") for three Strategic Mercyhealth CIRP groups that were designated to be fully-formed for earlier CYs 2015 and 2016 groups. The Board advised that the three complete Mercyhealth groups related to the SSI Calculation, SSI/Medicaid Part C Days, and Unmatched Medicaid Days, under Case Nos. 20-1729GC, 20-1730GC, and 20-1732GC respectively, all included only a single Provider: Mercy Health System Corp (Prov. No. 52-0066). Because, pursuant to 42 C.F.R. § 405.1837(b), a CIRP group is required to have two or more different providers, the Board identified the pending Mercyhealth CY 2017 CIRP groups that had a different originating Provider for two of the three issues.[1] The Board requested Strategic's comments regarding the Board's proposal to consolidate the CYs 2015 and 2016 CIRP groups into the CY 2017 groups. Specifically, with regard to the Unmatched Medicaid Days issue, the Board asked whether Strategic would be

[1] The Board also advised there was not a pending group for the Unmatched Medicaid Days issue, although Rockford included the issue in its CY 2017 individual appeal, Case No. 21-0220.

pursuing a CY 2017 CIRP group for Mercyhealth (because of Rockford Memorial Hospital's CY 2017 individual appeal which included the same issue), or whether the Unmatched Medicaid Days issue in Case No. 20-1732GC should be transferred back to the individual appeals for Mercy Health Corp for CYs 2015 & 2016.[2]

On September 24, 2021, Strategic responded to the Board's RFI and:

- Certified that there were no regulatory or factual changes for the SSI Calculation Error and Part C Days issues between CYs 2015, 2016 and 2017;
- Advised that its preference was to expand the Mercyhealth CY 2017 CIRP groups under Case Nos. 21-1345GC and 21-1443GC[3] to include CYs 2015 and 2016; and
- With regard to the Unmatched Medicaid Days issue, advised that Rockford was working on an administrative resolution in Case 21-0220 and, therefore, would not be forming a CY 2017 CIRP group for the issue.

On December 16, 2021 the Board proceeded with its intended action and expanded the CY 2017 CIRP groups under Case No. 21-1345GC and Case No. 21-1443GC to include CYs 2015 and 2016.

On June 2, 2022, Strategic confirmed that the Mercyhealth CY's 2015 - 2017 SSI Calculation Error CIRP Group was fully formed. The aggregate amount in controversy for the three participants in the group is $44,865.

Board Determination:

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

In addition, 42 C.F.R. § 405.1837 and Board Rule 12.2 both specify that a group appeal must have an aggregate amount in controversy of $50,000 or more. The Board finds that the subject group does not meet the minimum jurisdictional threshold requirement.

The Board has searched its database and was unable to locate any other Mercyhealth SSI Calculation Error Groups for other years with which this case could be combined. Therefore, the Board is electing to disband the subject group under Case No. 21-1345GC by transferring the SSI Calculation Error issue back to the participant's individual appeals as follows:

[2] A request to transfer the Unmatched Medicaid Days issue for Rockford Memorial from Case No. 21-0220 would require a further expansion of Case No. 20-1732GC to include CY 2017.
[3] Strategic also acknowledged the consolidation of the Medicaid Fraction Part C Days CIRP Group under Case No. 21-1444GC into Case No. 21-1443GC.

Provider	FYE	Case No.	Status
Rockford Memorial Hospital (14-0239)	6/30/2017	21-0220	Open
Mercy Health System Corp (52-0066)	6/30/2015	20-0278	Closed
Mercy Health System Corp (52-0066)	6/30/2016	20-0472	Closed

As indicated, Case Nos. 20-0278 and 20-0472, which are currently in a closed status, are hereby reinstated for the sole purpose of pursuing the SSI Calculation Error issue. Critical Due Dates notifications setting position paper deadlines will be issued for all three individual cases under separate cover, and will be exempted from Board Alert 19's suspension of Board filing deadlines. As there are no remaining participants in Case No. 21-1345GC, the group is hereby closed and removed from the docket.

Board Members:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

10/13/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5) (MAC for 21-0220)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Corinna Goron
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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case Nos. 14-2400GC, *et. al* (*see* attached listing marked as Appendix A)
Case Nos. 15-0555G, *et. al* (*see* attached listing marked as Appendix B)

Dear Mr. Ravindran:

As the parties are aware, Healthcare Reimbursement Services, Inc. ("HRS"), the Providers' designated representative, filed the following 2 separate *consolidated* requests for expedited judicial review ("EJR") identified as "Groupings" A and B involving, in the aggregate, 28 group cases and 273 participants:

Date of EJR Request	Lead Case	Groups	Participants in Aggregate	*Hereinafter Referred To As*
April 13, 2022	Case No. 14-2400GC	16 (*see* Appendix A)	131	"Grouping A"
April 19, 2022	Case No. 15-0555G	12 (*see* Appendix B)	142	"Grouping B"

Due to each grouping's sheer size (and age of the Grouping B cases), the recent closure of groups in each grouping, the number of Medicare contractors involved with each grouping, and anticipated jurisdictional challenges, Federal Specialized Services ("FSS"), the Medicare Contractors' representative, requested an extension of time to review the cases covered by Grouping A on April 15, 2022 and Grouping B on April 25, 2022. HRS did not oppose the extension requests FSS made in any of the groupings.

On April 26, 2022 for Grouping A and on May 4, 2022 for Grouping B, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Orders") taking the following actions for each group:

1. Granting FSS' extension in light of the number of cases involved in the EJR request, the number of participants within those cases, the number of Medicare contractors involved in those cases and the fact that the final Schedule of Providers ("SoP") for the vast majority of these cases was filed *within 60 days* of HRS' EJR request. The Board also took administrative notice of the hundreds of similar jurisdictional and substantive claim

reviews already being conducted with hundreds of other EJR requests filed prior to or concurrent with the instant EJR requests for the same issue. In the ruling on the extension request for Groupings A and B, the Board further noted that "[i]n the aggregate, these other unrelated EJR requests involve multiple thousands of participants and HRS has filed a significant share of these pending EJR requests."[1]

2. Assigning ongoing tasks to *both* parties to manage the jurisdictional review process for the cases within the relevant grouping; and

3. Issuing notice to the parties that the 30-day period for ruling on an EJR request *does not begin* until the Board completes its jurisdictional review process and finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2).

Following the Board's Scheduling Orders, the Providers were ***silent*** *and* HRS filed ***no objections*** *or requests for clarification regarding the Scheduling Order*. As a result, the Board and the Medicare Contractors continued to take actions consistent with that Scheduling Order.

On May 27, 2022, OAA notified the Board that HRS had filed a complaint in federal district court for the cases covered by Groupings A and B.[2] A review of public records confirmed that, on April 20, 2022, *without notice to the Board or the opposing parties in these cases*, HRS filed a Complaint in the U.S. District Court for the Central District of California ("California Central District Court") under Case No. 22-cv-02648. HRS bypassed and abandoned the Board's jurisdictional and EJR review process by prematurely seeking judicial review *on the merits* of its consolidated EJR request in the 28 group cases encompassed by Groupings A and B. This litigation was filed ***the day after HRS*** *filed its consolidated EJR request for Grouping B* ***and only 7 days after*** *it had filed its consolidated EJR request for Grouping A*. This timing demonstrates that HRS had no intention of allowing the Board to process its EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842 that implemented that statutory provision. HRS' failure to immediately notify the Board and the opposing parties of this concurrent filing demonstrates HRS' lack of good faith and the disingenuous nature of its filings before the Board.

HRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by HRS, the Board hereby attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to HRS initiating federal litigation in connection with consolidated EJR requests HRS filed on December 29, 2021, January 17, 2022, and February 27, 2022 involving 120 group cases for the same issue with 569 participants in the aggregate, as **Appendix D**.

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[1] Notice of Stay for Grouping A at n.10 (Apr. 26, 2022); Notice of Stay for Grouping B at n.9 (May 4, 2022).

[2] The Complaint in the California Central District Court for Case No. 22-cv-02648 makes clear at ¶¶ 3, 6, 34 with references to Exhibits A and B (copies of the consolidated EJR requests for Groupings A and B respectively) that litigation applies to all 28 group cases included in the consolidated EJR requests for Groupings A and B and the directive in 42 C.F.R. § 405.1842(h)(3)(iii) is clear as discussed *infra*. For example, ¶ 34 of the Complaint states "[t]he Hospitals in this action and Hospital fiscal years at issue are identified in the caption and Lists of Cases included with the request for EJR submitted by Plaintiffs attached as Exhibits A, B, C, D, and E." The Board is reviewing and reconciling OAA's request for records with the Complaint.

Procedural Background:

The Scheduling Orders issued in Groupings A and B explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[3] The Scheduling Orders further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework status. While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decision. Accordingly, the Scheduling Orders for Groupings A and B notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals. The notice for Grouping A and B[4] was as follows:

> The Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e*., **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. In this regard, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:
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> > Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days *after* it determines whether it has

[3] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[4] The Scheduling Order for Groupings A and B was virtually identical.

> jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.
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> Thus, it is clear that the 30-day clock does not start until *after* the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request.[5]

In addition, the Scheduling Orders set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that:

> A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request '[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]' [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request).[6]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, HRS did not file any objection to FSS' extension requests in Groupings A and B. Nor did HRS file any objection to the Scheduling Orders issued for Groupings A and B, much less notify the Board or the opposing parties that it had filed litigation in federal district court *concurrent* with the filing of its EJR requests. Rather, HRS was simply silent.

On June 8, 2022 and June 17, 2022, FSS complied with the Board's Scheduling Orders and filed jurisdictional and substantive claim challenges in distinct group cases. These challenges were different from, and in addition to, any pending, unresolved, jurisdictional challenges.

Notwithstanding the numerous jurisdictional issues and concerns identified by the Medicare Contractors and the Board,[7] HRS made clear by filing the Complaint in federal district court on April 20, 2022, that it was bypassing and abandoning the Board's jurisdictional review process. Even though HRS made this filing concurrent with its filing of the consolidated EJR requests in Groupings A and B, HRS never notified the Board of this litigation. It was only through an OAA request for records on May 27, 2022 that the Board learned of HRS' litigation.

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[5] (Footnote omitted and bold and underline emphasis added.)
[6] (Emphasis in original.)
[7] *See* **Appendix C**.

The avoidable delay in learning of HRS' bypassing and abandoning the Board's jurisdictional and EJR review process caused a significant waste of the Board's limited resources, as well as those of FSS and the Medicare Contractors servicing the 273 participants in the 28 group cases.[8] More concerning is HRS' concurrent filing of litigation without notice to the Board because it demonstrates HRS' bad faith and lack of intention to comply with the Board's Scheduling Orders and the administrative review process for EJR requests as mandated by 42 U.S.C. § 1395oo(f)(1). Through its actions, HRS essentially self-declared that, concurrent with the filing of the EJR request with the Board, the participants in these groups have an immediate right to pursue relief in federal district court (regardless of whether the Board has 30 days to review the EJR request, much less has jurisdiction over such providers). Indeed, if the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. To illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of open jurisdictional challenges and substantive claim challenges and some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional material jurisdictional issues would be identified if it were to complete the jurisdictional review process.

Board Findings:

The Board must consider the significant impact on the proceedings caused by HRS filing a lawsuit in connection with the above-referenced 28 group cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right 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, by a civil action commenced within sixty days of the date on which notification of such

[8] The Board takes administrative notice that it has a very large docket of pending cases (9142 as of May 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 19, 2022, ***in addition to*** *the 28 cases covered in this notice*, the Board had 344 cases with EJR requests pending. On or after April 20, 2022, when HRS filed its litigation in the California Central District Court, an additional 155 EJRs were filed in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate. The Board further notes that it experienced the record concentrations EJR requests being filed in the 6-month period from December 20, 2021 through June 30, 2022. Indeed, in this period, EJR requests covering 642 cases were filed of which close to 80 percent were filed by either by QRS and HRS (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases).

> determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[9]

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
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> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
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> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or

[9] (Emphasis added.)

> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
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> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
>
> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[10]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[11] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue

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[10] (Emphasis added).

[11] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

> *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[12]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[13] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[14] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
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> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the

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[12] (Emphasis added.)
[13] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[14] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).

> PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[15]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[16] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 28 group cases, with 273 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[17] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these 28 group cases.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction. HRS' filing of the Complaint in federal district court concurrently with the filing of its EJR request, without notice to the Board or opposing party, is contemptuous of the Board's authority.

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[15] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

[16] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on April 20, 2022***, HRS continued to take actions in the Board proceedings in these group cases (*e.g.*, withdraw participants or cases, file updated SoPs, file position papers, file jurisdictional documents or briefs, file responses to jurisdictional challenges, file responses to jurisdictional substantive claim challenges) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

[17] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

It also demonstrates that HRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request even under the interpretation of 42 U.S.C. § 1395oo(f)(1) that it is advocating.

B. Effect of HRS' Concurrent Filing of the Complaint on the 28 Group Cases

The regulation at 42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
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> ****
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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[18]

This regulation ***bars any further Board proceedings*** in these 28 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 28 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[19] and the May 23, 2008 final rule[20] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR,

[18] (Emphasis added.)
[19] 69 Fed. Reg. 35716 (June 25, 2004).
[20] 73 Fed. Reg. 30190 (May 23, 2008).

> we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[21]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[22]

[21] 69 Fed. Reg. at 3572.
[22] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that HRS' concurrent filing of the Complaint in the California Central District Court on April 20, 2022 prohibits the Board from conducting any further proceedings on the consolidated EJR requests for Groupings A and B as filed, including any proceedings related to the prerequisite jurisdiction.

C. HRS' Actions

The Board finds that HRS' decision to withhold notice from the Board and the opposing parties of its concurrent filing of the litigation is tantamount to bad faith and actively created the confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) and implemented at 42 C.F.R. § 405.1842. Indeed, HRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that HRS had no intention of exhausting its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[23] HRS had a duty to communicate early and in good faith with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), HRS, as the Providers' designated representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:

[23] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

- 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/ReviewBoards/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;
- 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.[24]

Indeed, the following inaction on HRS' part reinforces the Board's finding that HRS has no basis to claim that proceedings before the Board have been exhausted:

1. HRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file jurisdictional challenges in Groupings A and B.

2. HRS failed to notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Order for Groupings A and B. HRS' failure to file and preserve its objection to the Board's ruling and Scheduling Order violates HRS' obligations under Board Rules 1.3, 5.2, and 44, and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[25]

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[24] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[25] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[26] and Board Alert 19. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. The Board was not able to operate normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Orders for Groupings A and B to memorialize, and effectuate, the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. HRS failed to notify the Board of its objection to the Scheduling Orders. HRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, HRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[27] or take other actions, ***prior to*** HRS filing its April 20, 2022 Complaint. Indeed, HRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by HRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which HRS alleges in its litigation the Board missed)***, to pass, and, under HRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[28]

4. HRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of HRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that HRS had an affirmative obligation to notify the Board of the Complaint being filed, and that HRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Orders issued for these cases (as well as for cases well prior to April 20, 2022 as set forth in **Appendix D**), made clear the Board's position that the 30-day period for responding to the EJR request would not commence until the Board completed its jurisdictional review and issued its jurisdictional findings.

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out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule, it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

[26] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

[27] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* note 11, and accompanying text.

[28] *See supra* note 25 (discussing how the FRCP supports the Board's position).

b. Both the Board and the Medicare Contractors were acting in reliance on the authority of those Scheduling Orders.

c. Notwithstanding its April 20, 2022 filing of the litigation in the California Central District Court, HRS subsequently filed preliminary or final position papers in certain cases and included *disingenuous* "Good Faith" statements that "[d]ue to [insert name of issue, either "the SSI Fraction Dual Eligible Days CIRP issue" or "the DSH Medicaid Fraction Dual Eligible Days CIRP Group issue"], I assume we cannot seek a joint settlement or an agreement *and will need to proceed to the PRRB*."[29] The following are examples of cases in which position papers were filed subsequent to the Federal Complaint being filed:

- On April 25, 2022 for Case Nos. 19-2534GC, 19-2536GC, 19-1045GC and 19-1047GC.[30]
- On May 12, 2022 for Case Nos. 19-0805GC and 19-0807GC.[31]
- On June 6, 2022 for Case Nos. 14-2400GC, 14-3295GC, 14-3474GC and 15-2493GCGC.[32]
- On June 13, 2022 for Case Nos. 17-1461GC, 17-1462GC, 20-1254GC, 20-1256GC.[33]
- On June 17, 2022 for Case Nos. 20-1685GC and 20-1687GC.[34]
- On July 20, 2022 for Case Nos. 19-1541GC and 19-1543GC.[35]

In this regard, Board Rule 25.3 specifies "[t]he Board requires the parties file a complete preliminary position paper that includes . . . a statement indicating ***how a good faith effort to confer was made*** in accordance with 42 C.F.R. § 405.1853." Notwithstanding, HRS failed to disclose that, on April 20, 2022, it had initiated the litigation in the California Central District Court and instead represented it would "proceed to the PRRB."

5. HRS made the following disingenuous statement in ¶ 34 of the Complaint:

> The Hospitals now file this civil action in lieu of the PRRB's ruling on the five (5) requests for EJR . . . with the firm belief that the PRRB had no intention of deciding, and in fact will not decide, the Plaintiffs' EJR requests within thirty days as prescribed by

[29] (Emphasis added.)
[30] For each position paper, HRS made its "Good Faith Statement" in an attachment dated April 1, 2022.
[31] For each position paper, HRS made its "Good Faith Statement" in an attachment dated May 1, 2022.
[32] For each position paper, HRS made its "Good Faith Statement" in an attachment dated June 1, 2022.
[33] For each position paper, HRS made its "Good Faith Statement" in an attachment dated June 1, 2022.
[34] For each position paper, HRS made its "Good Faith Statement" in an attachment dated June 1, 2022.
[35] For each position paper, HRS made its "Good Faith Statement" in an attachment dated July 1, 2022.

> statue, or alternatively, should they so decide, they will as in past cases with identical issues grant EJR.

It is disingenuous because HRS failed to notify the Board of its objection to the Board's faithful application of 42 C.F.R. § 405.1842(b)(2) and did not permit the Board to potentially alter its planned course of action. It highlights the procedural quagmire that HRS created when it concurrently pursued litigation in federal court without notifying the Board.

D. Board Actions

These circumstances make clear that HRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, HRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, April 20, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these 28 group cases and the underlying 273 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by HRS and other representatives. Indeed, HRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the California Central District Court, as well as the earlier litigation joined on March 30, 2022 (as discussed in great detail in **Appendix D**) raises very serious concerns about prejudicial sandbagging by HRS to benefit prior, current and subsequent EJR requests that HRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue that HRS joined in its litigation in the California Central District Court.[36] More specifically, it is the Board's understanding that QRS had, on February 14, 2022, established the ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that HRS *joined* QRS in that lawsuit when an Amended Complaint was filed on March 30, 2022 incorporating 120 cases involving 550+ participants into that lawsuit (without any notice to the Board or the opposing party). The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 cases (with the overlay of challenges arising from the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period, as discussed *infra*); and

[36] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

2. 80 percent of these requests were filed by either QRS or HRS (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).

For a point of reference and context for these serious violations by HRS, the Board has included as **Appendix D** a copy of the closure letter it issued in those 120 HRS cases that were included in the March 30, 2022 Federal Complaint. Finally, it is the Board's understanding that HRS and QRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 and that HRS' joinder covers the EJR requests for Groupings A and B without completing the jurisdictional review process and without notice to the Board.[37]

It is clear the Providers are pursuing the merits of their cases in Groupings A, B, and C as part of the lawsuit (even as it relates to the 15 group cases in which the Board denied EJR within 30 days of the EJR request being filed for clear fatal jurisdictional defects as discussed in **Appendix C**). Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[38] However, the Board cannot permit HRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded to it for further proceedings*, the Board will complete its jurisdictional review and weigh the severity of HRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[39] Examples of available remedial actions that the Board may consider to vindicate the authority of the Board based upon HRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the 28 group cases and all underlying participants.

2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.

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[37] *See supra* note 2. Under separate cover, the Board closed the QRS cases by letter dated September 30, 2022, and it included similar findings as in these HRS group cases.

[38] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[39] The Board's planned actions are consistent with those planned for HRS and QRS as laid out in **Appendix D**.

3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[40] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
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> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be

[40] 42 C.F.R. § 405.1868 states:

> (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.

(Emphasis added.)

> less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[41]

Pursuant to the above, the Board has broad authority to sanction HRS for its repeated, and ongoing, malfeasance.

E. Board Decision and Order

Based on HRS' misconduct, the Board hereby takes the following actions:

1. Closes these 28 group cases (to the extent they are not already closed[42]) consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends:

   - The ongoing jurisdictional review process;

   - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[43] filed in Case Nos. 19-1045GC, 19-1047GC, 20-1685GC, and 20-1687GC[44] and, as a result, must issue findings pursuant to § 405.1873(d)(2) on these particular participants' compliance with the "appropriate cost report claim" requirements in § 413.24(j), if the withdrawal of these group cases subsequent to the Board were to find jurisdiction and issue an EJR decision;[45] and

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[41] 73 Fed. Reg. at 30225.

[42] There are 2 group cases in Grouping A that the Board closed *prior to this letter* and this letter supplements that closure. The 2 group cases are Case Nos. 20-1254GC and 20-1256GC (with aggregate amounts in controversy ("AiCs") of $837,264 and $1,086,988 respectively) and the Board closed them on an automated basis in acknowledgement of HRS filing notice of its withdrawal of those cases (which per Board Rule 46 is self-effectuating). Specifically, HRS filed its withdrawal of those cases on July 18, 2022 after the FSS filed on July 18, 2022 a substantive claim challenge for all the participants in the groups. However, HRS failed to disclose in its withdrawal notice that it had filed litigation to pursue the merits of these cases in federal court roughly 3 months earlier on April 20, 2022 (much less how these withdrawals impacted that litigation given that the 2 cases are part of that litigation). *See supra* note 2 (confirming the litigation encompasses these 2 cases). The Board has noted in Appendices A and B which cases are already closed as well as when and why that closure occurred by cross referencing this footnote. If a remand of these 2 cases were to occur, the Board would treat these two appeals as withdrawn and abandoned unless specifically instructed otherwise in the remand order.

[43] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j)*.

[44] The Medicare Contractors also filed substantive claim challenges in Case Nos. 20-1254GC and 20-1256GC. However, HRS withdrew those cases ***after*** HRS filed its EJR request and after HRS filed its Complaint in the California Central District Court. *See supra* note 42.

[45] Per 42 C.F.R. § 405.1873(e), the Board does not issue final substantive claim findings if the Board issues a jurisdictional dismissal decision or the Board denies EJR.

3. Defers consideration of citing HRS for contempt and dismissing these group cases (and/or taking other remedial action to vindicate the authority of the Board) based on HRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[46]

Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

10/19/2022

X Clayton J. Nix

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

Enclosures:

Appendix A – Case List for Grouping A
Appendix B – Case List for Grouping B
Appendix C – Interim List of Potential Jurisdictional, Substantive Claim, & Procedural Violations Under Review
Appendix D – Sept. 23, 2022 Board Letter to HRS Deferring Show Cause Order & Closure of Cases (70 pages with enclosures)

cc:

Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Adm'rs
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[46] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,

APPENDIX A

Grouping A – List of the 16 Group Cases Covered by the Consolidated Request for EJR Filed on April 13, 2021

14-2400GC Cleveland Clinic 2009 SSI Fraction Dual Eligible Days CIRP
14-3295GC Cleveland Clinic 2010 SSI Fraction Dual Eligible Days CIRP Group
14-3474GC Cleveland Clinic 2011 SSI Fraction Dual Eligible Days CIRP Group
15-2493GC Cleveland Clinic 2012 SSI Fraction Dual Eligible Days CIRP
16-1703GC HRS Prime Healthcare 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
16-1704GC HRS Prime Healthcare 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-1461GC HRS Lafayette General Health 2012-2014 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1462GC HRS Lafayette Gen. Health 2012-2014 DSH Medicaid Fract. Dual Eligible Days CIRP Group
19-0805GC HRS Willis-Knighton CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0807GC HRS Willis-Knighton CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-1541GC HRS The Queens Health Systems CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-1543GC HRS The Queens Health Systems CY 2016 DSH Medicaid Fract. Dual Elig. Days CIRP Group
19-2534GC HRS Lafayette General Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2536GC HRS Lafayette General Health CY 2017 DSH Medicaid Fract. Dual Eligible Days CIRP Group
20-1254GC HRS Cleveland Clinic Fdn. CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group[47]
20-1256GC HRS Cleveland Clinic Fdn. CY 2017 DSH Medicaid Fraction Dual Elig. Days CIRP Group[48]

[47] *See supra* note 42 (discussing how and why this case was already closed after HRS had filed its EJR request and the litigation in the California Central District Court).
[48] *See supra* note 42 (discussing how and why this case was already closed after HRS had filed its EJR request and the litigation in the California Central District Court).

APPENDIX B

Grouping B – List of the 12 Group Cases Covered by the Consolidated Request for EJR Filed on April 19, 2022

15-0555G	HRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-0556G	HRS 2012 DSH Medicaid Fraction Dual Eligible Days Group
17-1607GC	HRS Prime Healthcare 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-1608GC	HRS Prime Healthcare 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1972GC	HRS ProMedical Health Sys. 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-1973GC	HRS ProMedical Health System 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
18-0997GC	HRS ProMedical Health System 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
18-0998GC	HRS ProMedical Health Sys. 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-1045GC	HRS ProMedical Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-1047GC	HRS ProMedical Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
20-1685GC	HRS ProMedical Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group
20-1687GC	HRS ProMedical Health CY 2017 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX C

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[49]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process. This process is exponentially more complex when consolidated EJR requests are concurrently filed involving 28 group cases with 273 participants.[50]

In compliance with the Board's Scheduling Order in Groupings A and B, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. These challenges, as well as separate challenges or jurisdictional issues raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges were raised claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case No. 15-0555GC.

- Jurisdictional issues were raised in Case No. 15-0555GC claiming that the Board lacks jurisdiction over certain participants' appeal of the non-issuance of an NPR because that appeal was premature based on the fact that, subsequent to the filing of the cost report at issue, these participants filed amended "perfected" cost reports.

- A jurisdictional challenge in Case No. 15-0555GC claims that HRS improperly included 2 participants on the final Schedule of Providers ("SoP") even though HRS had previously withdrawn those participants.

- Substantive claim challenges[51] were filed in Case Nos. 20-1254GC, 20-1256GC,[52] 19-1045GC, 19-1047GC, 20-1685GC and 20-1687GC claiming that one or more of the participants failed to include an appropriate claim for the appealed item in dispute, as required under 42 C.F.R. § 413.24(j).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 28 group cases, has identified ***numerous, material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Providers With No Appeal Rights*.—The instant cases do contain participants that appealed revised NPRs. The regulation at 42 C.F.R. §405.1889(b) instructs that these participants

[49] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 28 group cases.
[50] *See supra* notes 11, 16.
[51] *See supra* note 17 (discussing what the Board's use of the term "substantive claim challenge" means).
[52] *See supra* note 42 (discussing how and why Case Nos. 20-1254GC and 20-1256GC were closed).

have appeal rights and may only appeal matters that are specifically adjusted. The Board is reviewing the revised NPR appeals to confirm whether the Board has jurisdiction over these participants. This review encompasses but is not limited to those revised NPR appeals cited by the Medicare Contractor.

2. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— For those appeals that are based on a determination such as an NPR or revised NPR, 42 C.F.R. § 405.1835(a)(3) (2013) specifies that "[u]nless 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 date of receipt by the provider of the final contractor or Secretary determination." As the date of Provider's receipt of the determination is presumed to be 5 days after the date the final determination is issued,[53] an appeal request of a determination effectively must be filed with the Board within 185 days of the determination in order to be considered timely.

   Similarly, for appeals based on the nonissuance of an NPR, 42 C.F.R. § 405.1835(c)(2) specifies that: "[u]nless 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) . . .)." In this instance, the appeal must be filed within 12 months of the Provider's filing of the relevant perfected cost report.

   The Board is reviewing whether participants failed to timely appeal and expects that it may identify situations where participants did, in fact, fail to timely appeal given the fact that, in a number of cases where certain participants appealed from the nonissuance of an NPR, the Board requested additional documentation to establish the date the Provider filed the perfected cost report at issue.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants*.— There are a significant number of participants in these 28 groups for whom HRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers attached to the EJR (which is, in turn, attached to the Complaint filed in the California Central District Court[54]) even though either ***HRS*** had ***previously withdrawn*** them from the relevant group case,[55] ***and/or*** the Board dismissed them and/or denied their transfer to the group appeal. Although the Board has not yet completed its review, the following examples show where HRS is ***improperly*** pursuing reimbursement *for close to $500,000*. Once HRS' withdrawals of Case Nos. 20-1254GC and 20-1256GC *made subsequent to* its filing of the April 20, 2022

[53] 42 C.F.R. § 405.1801(a) includes the definition for "date of receipt" and paragraph (1)(iii) of that definition explains that "[t]his [5-day] presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."
[54] *See supra* note 2.
[55] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

Complaint are taken into account, *the amount of* ***improper*** *reimbursement being pursued* ***exceeds $2.4 million*** as these 2 cases alone had aggregate amounts in controversy ("AiCs") of $837,264 and $1,086,988.[56] Such action on the part of HRS raises significant fraud and abuse concerns,[57] and the Board takes administrative notice that this is not an isolated concern as discussed in **Appendix D** at pages 11 to 16. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[58] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings*. Included on pages 11 to 16 of **Appendix D** are recent examples of group cases in which the Board has identified that HRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals. These examples highlight, *at a minimum*, HRS' reckless disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 540 open cases as of early June (of which there were more than 400 CIRP groups and 80 optional groups), HRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.

a. *Case Nos. 16-1703GC and 16-1704GC*.—For each of these groups, HRS filed the Final SoP on March 1, 2021 and it includes Participant #20A/20B Garden City Hospital for FYE 6/30/2014, Participant #21 Garden City Hospital for FYE 12/31/2014, Participant #23 St. Mary's Hospital Passaic for FYE 6/30/2014, and Participant #24 St. Mary's Passeic for FYE 12/31/2014 having AiCs of $6,997, $6,338, $9,223, and $6,077 respectively. A year later, on March 17, 2022, HRS filed notice of its withdrawal of these 4 participants and included an updated summary SoP table. Notwithstanding this withdrawal, when HRS filed the consolidated EJR request for Grouping A (roughly 4 weeks later on April 13, 2022), it *failed* to reflect these withdrawals in the summary SoPs for these cases that is attached to that EJR request. As the Complaint filed in district court represents that the providers listed in the summary SoP tables attached to the EJR requests filed for Groupings A and B are all part of the litigation,[59] it is unclear to what extent the withdrawal would (or could) be recognized and effectuated in the litigation in the California Central District Court.

b. *Case Nos. 15-0555G and 15-0556G*.— For each of these optional groups, the Board's records reflect that HRS filed withdrawal notices for both Participant #8A/8B

[56] *See supra* note 42.
[57] Based on its preliminary review of just some of these cases, the Board fully expects to identify other situations where HRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of some of the SoPs that HRS refiled and is relying upon for its consolidated EJR requests.
[58] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).
[59] *See supra* note 2.

MetroHealth and Participant #10A/10B Lima Memorial Hospital on November 14, 2016. For each case, these participants had AiCs of $19,087 and $154,424 respectively. Notwithstanding these withdrawals, the final SoPs filed for these cases (and attached to the EJR request) included these participants.

c. *Case Nos. 17-1607GC and 17-1608GC*.—For each of these CIRP groups, on April 11, 2022, HRS withdrew Participant #14, Monroe Hospital (Prov. No.), Participant #20 St. Mary's Regional Medical Center (Prov. No. 29-0009) and Participant #21 St. Mary's Hospital - Passaic (Prov. No. 31-0006) having AiCs of $259, $22,008, and $15,602 respectively. HRS filed an updated summary SoP on April 13, 2022 that reflected the withdrawal of these 3 providers. However, the EJR request did not have the updated SoP attached and still included Participant ##14, 20, and 21 and the Complaint filed in district court includes the EJR request with the uncorrected SoPs. As a result, it appears that HRS is still pursuing the merits of these participants' claims in federal district court.[60]

4. *Unauthorized Representation of Participants*.— The Board has also identified situations where HRS ***failed*** to obtain proper authorization from the provider to be a participant in the relevant group.[61] For example, in Case Nos. 17-1607GC and 17-1608GC, HRS included in the final SoPs a global representation letter from Prime Healthcare dated April 13, 2018 for all participants. As April 13, 2018 is well after the groups were established on June 1, 2017, the Board is reviewing dismissal of any participants prior to that date, including but not limited to Participant #18 North Vista Hospital (FYE 2/28/2015) which was directly added to the group on June 1, 2017. The Board expects it will identify additional unauthorized representation issues once it completes the jurisdictional review process based on its recent experiences with HRS' SoP filings in group cases.

5. *Failure to meet minimum $50,000 AiC requirement for a group appeal*. —As explained in 42 C.F.R. § 405.1839(b), "[i]n order to satisfy the amount in controversy [or AiC] requirement . . . for a Board hearing as a group appeal, the group must *demonstrate* that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."[62] Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." The following are examples of group cases that that Board is reviewing to determine whether the group failed to meet the minimum $50,000 AiC requirement. The Board expects that it would identify additional AiC issues if it were

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[60] *See supra* note 2.

[61] Per Board Rule 6.4 (Mar.2013, July 2015), "An authorized representative of the Provider must sign the appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider." The Board requires provider-executed letters of representation to be filed with the appeal in order to protect providers and health chains from potentially coercive or abusive representation situations, whether in the context of an individual or group appeal.

[62] Consistent with 42 C.F.R. § 405.1840(a), Board Rule 6.3 (2013) requires that "*[f]or each issue*, provide a calculation or support demonstrating the amount in controversy." (Emphasis added.)

to complete its jurisdictional review, and such issues may include: (1) failure to document in the final SoP that the group meets the minimum $50,000 threshold ***for the group issue*** as explained at 42 C.F.R. § 405.1839(b);[63] and (2) the dismissal of participants for other reasons which may cause the group to fail below the minimum $50,000 AiC threshold.[64]

a. *Case Nos. 14-2400GC, 14-3295GC, 14-3474GC, and 15-2493GC*.—The Board is reviewing whether each of these groups documented that it met the minimum $50,000 AiC requirement *for the group issue*. Here, the final SoPs for these groups simply includes a generic 1 percent estimated impact applied to the DSH payment as a whole without explaining the basis for the 1 percent estimated impact or how that relates to the days at issue in either the Medicare or Medicaid fractions specifically. Moreover, the Board notes that the sole participant used to establish each of these groups had an AiC calculation that only impacted the SSI fraction and this AiC estimate reflects the addition of SSI days to the numerator of the SSI fraction (which is in contrast to the EJR request which is asserting that no pay Part A days should be removed from both the numerator and denominator of the SSI fraction and that the subset of dual eligible days should be added to the numerator of the Medicaid fraction). As a result, the Board is also reviewing the nature and scope of the appeal, as discussed below, to determine whether the EJR request is outside the scope of these group appeals, whether the appeals encompassed the Medicaid fraction, and whether the appeals violate the prohibition on multiple issues in a single appeal.

b. *Case Nos. 16-1703GC, 16-1704GC, 17-1461GC, 17-1462GC, 15-0555G, 15-0556G, 17-1607GC, 17-1608GC, 17-1972GC, 17-1973GC, 18-0997GC, and 18-0998GC*.—In the final SoPs for these groups, HRS included generic AiCs for participants. Specifically, for participants, HRS simply includes a generic 1 percent estimated impact applied to the DSH payment as a whole without explaining the basis for the 1 percent estimated impact or how that relates to the days at issue in either the Medicare or Medicaid fractions specifically. Accordingly, the Board is reviewing whether HRS provided sufficient documentation to demonstrate it met the minimum $50,000 AiC threshold for a group.

6. *The Compliance of Commonly Owned/Controlled Providers with the CIRP group requirements*.—Pursuant to 42 C.F.R. § 405.1837(b)(1):

> 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

[63] The Board is aware of situations where the AiC calculation in the SoP is not for the group issue or fails to be a good faith calculation (*i.e*., fails to explain the basis for the AiC calculation).
[64] As a significant portion of the groups are small or close to the minimum $50,000 AiC threshold, it is likely that a number of groups may fail to meet this threshold once the Board completes its jurisdictional review.

> controversy is $50,000 or more in the aggregate, ***must bring the appeal as a group appeal***.[65]

In these situations, the commonly owned/controlled providers must establish a common issue related party ("CIRP") group. There are two optional group in the instant 28 cases, Case Nos. 15-0555G and 15-0556G, and the Board is reviewing compliance with the mandatory CIRP group rules because the Board has identified participants in these groups as being potentially subject to the mandatory CIRP group requirements. For example, Participant #1 Fayette Medical Center is part of the DCH Health System ("DCH") as evidenced by both the letter of representation on DCH letterhead included behind Tab 1H in the final SoPs filed for these cases ***and*** the Worksheet E Part A of the cost report included in the appeal request which identifies the participant as "Fayette Medical Center **DCH** – Fayette, AL."[66] The Board is reviewing dismissal of this participant because HRS also had 2012 DCH CIRP groups for this issue under Case Nos. 15-2402GC and 15-2403GC which were part of the EJR request filed on February 27, 2022 that the Board closed by the letter in **Appendix D** dated September 23, 2022.

7. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in these 28 groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[67] The Board expects it would identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

8. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues; one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation.[68] Thus, for

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[65] (Emphasis added.)
[66] SoP for Case Nos. 15-0555GC, 15-0556GC at Tab 1B, page 25 (emphasis added); *id*. at Tab 1D (emphasis added).
[67] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.
[68] The Board takes administrative notice that views the challenge to the Secretary's 2004 policy to include no pay Part A days in the Medicare fraction as a separate issue from the inclusion of the subset of those days in the Medicaid fraction and, to that end, has been reversing mergers of companion SSI fraction dual eligible days cases with Medicaid fraction dual eligible days cases that were made in error. In support of this position, the Board points to the Ninth Circuit's decision in *Empire* where they overturned the 2004 policy change but simply reverted to the prior policy that resulted in no-pay Part A days being counted in neither fraction. *See Empire Health Found. v. Azar*, 958 F.3d 873, 886 (9th Cir. 2020) ("reinstat[ing] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days", *i.e*., reinstating the rule previously in force). Similarly, the Board points to CMS Ruling 1498-R2 confirming that no

each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies. An example is in Case No. 19-2534GC (entitled "HRS Lafayette General Health CY 2017 DSH SSI Fraction Dual Eligible Days CIRP Group") where the Board is reviewing the extent to which the EJR request applies to Participant #4 Acadia General Hospital since this hospital is not a participant in the companion case under Case No. 19-2536GC (entitled "HRS Lafayette General Health CY 2017 DSH Medicaid Fraction Dual-Eligible Days CIRP Group").

9. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[69] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The 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

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pay Part A days were not counted in either fraction prior to 2004. CMS Ruling 1498-R2 at 3 (stating "Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098)." (emphasis added)). *See also* CMS Ruling 1498-R.

[69] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bold emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

the group.[70] The Board is reviewing whether the Providers' consolidated EJR requests filed for Groupings A, B and C are challenging multiple interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[71]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[72]). If true, it raises immediate jurisdictional problems of whether the additional challenges are *properly* part of the relevant groups[73] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues and, as relevant, whether it requested transfer of those additional issues to the group; and (2) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[74] A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years.

Notwithstanding the above jurisdictional issues and concerns, HRS made clear with the April 20, 2022 filing of the Complaint in federal district court that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above). Even though HRS made this filing the day it filed the consolidated EJR request in Grouping B and only 7 days after it filed the consolidated EJR request in Grouping A, HRS never notified the Board of this litigation for either Grouping.

The delay in learning of HRS' bypassing and abandoning the Board's jurisdictional and EJR review process by virtue of the OAA request for records has caused significant waste of the

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[70] (Emphasis added.)

[71] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[72] *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[73] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[74] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following cases and that these position papers include not just the *Empire* issue but also another separate and distinct issue that the Board refers to in Board Rule 8 as the SSI eligible days issue embodied in PRRB Dec. No. 2017-D12:

- On April 25, 2022 for Case Nos. 19-2534GC, 19-1045GC.
- On May 12, 2022 for Case No. 19-0805GC.
- On June 6, 2022 for Case Nos. 14-2400GC, 14-3295GC, 14-3474GC and 15 2493GCGC.
- On June 13, 2022 for Case Nos. 17-1461GC and 20-1254GC.
- On June 17, 2022 for Case No. 20-1685GC.
- On July 20, 2022 for Case No. 19-1541GC.

The arguments made in these position papers supports the Board's position that the SSI eligibility issue is a separate issue from the *Empire* no pay Part A days issue because each issue involves a different interpretation of the relevant statutory provisions, is challenging a different regulatory provision, and seeks different relief since they each involve different types of days (one is seeking removal of no pay Part A days from all of the Medicare fraction while the other is seeking the addition of SSI eligible days to the numerator of the Medicare fraction). *See* 42 C.F.R. §§ 405.1835(b), 405.1837(c); Board Rules 7, 8, 12.2, 13, 16, 16.2. *See also supra* note 68.

Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 273 participants in the 28 group cases.[75] More concerning is HRS' concurrent filing of litigation without notice to the Board because it is tantamount to bad faith and demonstrates that HRS had no intention of complying with the administrative review process for EJR requests as mandated by 42 U.S.C. § 1395oo(f)(1) which necessarily includes first determining whether an EJR request is ripe (*i.e*, whether the Board has jurisdiction). HRS essentially self-declared that, concurrent with the filing of the EJR request in federal court, the participants in these groups have an immediate right to pursue EJR in federal district court (regardless of whether the Board has 30 days to review the EJR request, much less has jurisdiction over such providers). Indeed, if the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.

[75] The Board takes administrative notice that it has a very large docket of pending cases (9142 as of May 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 19, 2022, ***in addition to*** *the 28 cases covered in this notice*, the Board had 344 cases with EJR requests pending. On or after April 20th, 2022, when HRS filed its litigation in the California Central District Court, an additional 144 EJRs were filed in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate.

APPENDIX D

September 23, 2022 Board Letter to HRS to Close Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to HRS Filing Litigation in California Central District Court

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case Nos. 13-3115GC, *et. al* (*see* attached listing marked as Appendix A)
Case Nos. 14-0416G, *et. al* (*see* attached listing marked as Appendix B)
Case Nos. 15-0007GC, *et. al* (*see* attached listing marked as Appendix C)

Dear Mr. Berends and Ms. Goron:

As the parties are aware, Healthcare Reimbursement Services ("HRS"), the Providers' designated representative, filed the following 3 separate consolidated requests for expedited judicial review ("EJR") identified as "Groupings" A, B, and C and involving, in the aggregate, 120 group cases and 569 participants:

Date of EJR Request	Lead Case	Groups	Participants in Aggregate	*Hereinafter Referred To As*
Dec. 29, 2021	Case No. 13-3115GC	63 (*see* Appendix A)	255	"Grouping A"
Jan. 17, 2022	Case No. 14-0416G	40 (*see* Appendix B)	200	"Grouping B"
Feb. 27, 2022	Case No. 15-0007GC	17 (*see* Appendix C)	114	"Grouping C"

The Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review the cases covered by Groupings A, B and C on January 6, 2022, January 27, 2022 and March 4, 2022 respectively due to the sheer size of each grouping, the number of Medicare contractors involved with each grouping, and already pending[1] or planned[2]

[1] FSS' Response to the consolidated request for EJR for Grouping A identified the jurisdictional challenges ("JCs") as being pending and unresolved in the following group cases:
- Case No. 15-3345G (JC filed May 14, 2018 challenging Provider No. 12-0001 on the grounds that the individual appeal request was untimely; and
- Case No. 15-3346G (JC filed May 14, 2018 challenging Provider No. 12-0001 on the grounds that the individual appeal request was untimely.

[2] For Grouping B, FSS' response to the consolidated request asserted that JCs or substantive claim challenges were going to be filed in the following group cases:
- A JC in Case No. 14-1522GC as two providers (Prov. Nos. 05-0739 and 41-0011) are appealing from revised NPRs that do not pertain to the appeal issue in this case;
- A JC in Case No. 14-1523GC as there was no adjustment to the Medicaid fraction in the revised NPRs and several providers (Prov Nos 31-0006 and 31-0096) are not proper participants in the group;
- A JC in Case No. 14-2930GC as there was no adjustment to the Medicaid fraction for Provider No. 39-0016;

jurisdictional challenges in certain cases. In Grouping A, HRS filed its opposition to FSS' extension request alleging that the Medicare Contractors have had enough time to review the relevant jurisdictional documents for Grouping A because "the MAC has had most of these documents for months and in some cases years." HRS did not oppose the FSS extension requests made in Groupings B and C.

On January 18, 2022, January 28, 2022 and March 16, 2022 for Groupings A, B, and C respectively, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") taking the following actions for each group:

1. Granting FSS' extension in light of the number of cases involved in the EJR request, the number of participants within those cases, and the number of MACs involved in those cases and the fact that the final SOP for the majority (if not virtually all) of these cases was filed *within 60 days* of HRS' EJR request[3];

2. Issuing a Scheduling Order to manage the jurisdictional review process for the cases within the relevant grouping and assigning ongoing tasks to *both* parties; and

3. Issuing notice to the parties of the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2).

Following the Board's Scheduling Order, the Providers were ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order*. As a result, the Board and the Medicare Contractors continued to take actions consistent with that Scheduling Order.

On May 6, 2022, the Board received a request from OAA that asked for a copy of the administrative record as HRS had filed suit in federal district court on these 120 group cases. A review of public records confirmed that, on March 30, 2022, without notice to the Board or the opposing parties in these cases, HRS bypassed the ongoing jurisdictional review process by joining an already-pending lawsuit in the U.S. District Court for the Central District of California ("California Central District Court") under Case No. 22-cv-00989 seeking judicial review on the merits of its consolidated EJR request in these 120 group cases encompassed by Groupings A, B, and C. Significantly, this

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- A substantive claim challenge (*see infra* note 4) in Case No. 20-1801GC and 20-1803GC as Prov. No. 12-0028 did not include the group issue in its protested items on the as filed cost report at issue.

Similarly, for Grouping C, FSS' response to the consolidated request asserted that JCs or substantive claim challenges were going to be filed in the following group cases:

- A JC in Case No. 15-2680GC as Prov. No. 05-0518 appealed an issue beyond the adjustments in the revised NPR at issue and Prov. Nos. 05-0588 and 05-0709 are duplicates since these Providers appealed from a failure to issue a timely determination and then appealed from the NPR; and
- A JC in Case No. 15-2681GC as Prov. Nos. 05-0588 and 05-0709 are duplicates since these Providers appealed from a failure to issue a timely determination and then appealed from the NPR.

[3] For Grouping A, the Board noted that HRS generally filed SOPs with supporting documentation several days prior to or concurrent with the EJR request. It is not readily apparent to what extent those SOP documents differ from the earlier versions previously filed with the Board. Indeed, in some cases there had been subsequent withdrawals and transfers. Given that there are 63 cases in Grouping A and the fact that an SoP can be quite lengthy (*e.g.*, the SoP for Case No. 14-1059 for just 3 participants is 175 pages long), it would have been an intolerable burden to resolve those issues across the 63 cases in the Grouping while also conducting a thoughtful review of those SoP documents in the Grouping.

litigation was established by another representative, Quality Reimbursement Services ("QRS") on February 14, 2022 under similar circumstances relating to an EJR request for the same issue for 80 group cases covering 950+ participants. As the Board took actions similar to those being taken here and the litigation is intertwined, the Board has attached as **Appendix D** a copy of the closure letter issued in the 80 QRS group cases.

As set forth in more detail below, the Board hereby takes the following actions:

1. Closes these 120 cases (to the extent they are not already closed[4]) consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Suspends completion of:

   - The ongoing jurisdictional review process;

   - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[5] filed in Case Nos. 20-1801GC and 20-1803GC and, as a result, must issue findings pursuant to § 405.1873(d)(2) on these particular participants' compliance with the "appropriate cost report claim" requirements in § 413.24(j), if the Board were to find jurisdiction and issue an EJR decision;[6] and

   - Defers action on the numerous, egregious, regulatory violations, until such time as there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[7]

Procedural Background

The Scheduling Order issued in Groupings A, B, and C explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[8] The Scheduling Order further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework

[4] There are a number of cases that were closed either prior to the relevant consolidated EJR request being filed or afterwards. The Board has noted in Appendices A, B and C which cases are already closed as well as when and why that closure occurred.

[5] As explained in Board Rule 44.5, "the Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items" ***as required*** *by 42 C.F.R. § 413.24(j)*.

[6] Per 42 C.F.R. § 405.1873(e), the Board does not issue final substantive claim findings if the Board issues a jurisdictional dismissal decision or the Board denies EJR

[7] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,

[8] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions /phe/Pages/default.aspx.

status.[9] While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decision. Accordingly, the Scheduling Order notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals. The notice for Grouping B[10] was as follows:

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. Based on the foregoing, the Board (1) will follow the standards set forth in the CMS regulations at 42 C.F.R. § 405.1801(d)(2) when calculating the Board's 30-day time period by excluding all days where the Board is not able to conduct its business in the usual manner; and (2) has stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.[11]

In addition, the Scheduling Order set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Further, for Groupings A and B, the Board requested that the record in these cases be supplemented with certain germane information from the individual appeals, from which participants had been transferred, to ensure the record before the Board was complete for purposes of the Board's jurisdictional review.[12] Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that:

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[9] *See also infra* note 62.

[10] The Scheduling Order for all three Groupings was virtually identical to this example.

[11] Grouping B Board Ruling on FSS' Extension Request Relating to HRS' Request for EJR Request in 40 Groups at 1-2 (Jan. 28, 2022) (footnote omitted and bold and underline emphasis added.)

[12] Specifically, for Groupings A and B, the Board stated: "The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case* ***so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases***." Grouping A Board letter (Jan. 18, 2022) (emphasis added); Grouping B Board letter (Jan. 28, 2022).

> A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request '[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]' [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request).[13]

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, while HRS timely filed an objection to FSS' request for extension in Grouping A, HRS did not file any objection to FSS' extension requests in Groupings B and C, even though it had the benefit of the Board's rationale to grant FSS' request in Grouping A. Nor did HRS file any objection to the Scheduling Order issued for Groupings A, B, and C. HRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and filed jurisdictional challenges in distinct group cases. These challenges were different from, and in addition to, pending, unresolved, jurisdictional challenges that FSS noted in its response (as well as others not noted).[14]

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced 120 cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right 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, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such

[13] (Emphasis in original.)
[14] *See supra* notes 1-3.

> documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[15]

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
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> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
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> ****
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> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
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> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or
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> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.

[15] (Emphasis added).

> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.
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> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[16]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[17] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[18]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers

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[16] (Emphasis added).

[17] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

[18] (Emphasis added.)

participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[19] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[20] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
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> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[21]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations,

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[19] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[20] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[21] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[22] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 120 group cases, with over 569 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[23] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these 120 group cases.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Case and the Board's Jurisdictional Review

In compliance with the Board's Scheduling Order in Groupings A, B, and C, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. These challenges, as well as separate challenges or jurisdictional issues raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case Nos. 14-1522GC, 14-1523GC, 14-0366G, 14-0416G, 14-1768GC, and 19-2067.

- Jurisdictional challenges claiming that Case Nos. 16-1317GC and 16-1318GC are not valid because each group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for these groups.

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[22] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.

[23] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

- Jurisdictional issues noted in Case Nos. 15-3345G, 15-3346G, and 19-2067G regarding certain participants that failed to *timely* file their individual appeal request or direct add to the group within the 180-day period required under 42 C.F.R. § 405.1835(a)(3).[24]

- Jurisdictional challenges filed in Case Nos. 14-2930, 15-2656G and 15-2657G allege that certain providers did not include a claim for the item on their cost report and did not identify the item as a self-disallowed cost by identifying the issue as a protested amount on their cost report.

- A jurisdictional challenge filed in Case No. 15-2189GC alleges that HRS failed to provide records in the final SoP to establish that one participant was timely, and properly added to the group and, thus, that provider should be dismissed.

- A substantive claim challenge[25] was filed on June 1, 2022 for Case Nos. 20-1801GC and 20-1803GC claiming that none of the providers included an appropriate claim for the appealed item in dispute, as required under 42 C.F.R. § 413.24(j). On July 5, 2022, HRS responded by filing a withdrawal of North Hawaii Community Hospital and requesting that, since the withdrawal leaves a single provider in each of these groups, the Board combine these groups with the Queens Health System CIRP groups for the same issue for 2018, namely Case Nos. 21-1165GC and 21-1167GC. Significantly, HRS acknowledges that neither Case No. 21-1165GC nor Case No. 21-1167GC are fully formed. This would suggest that HRS would be withdrawing its EJR request in Case Nos. 20-1801GC and 20-1803GC. However, HRS failed to acknowledge that it was pursuing the merits of the EJR request in federal district court based on the complaint it filed on March 30, 2022. Indeed, given the facts that the withdrawal is not reflected in the relevant SoPs attached to the EJR requests and that the withdrawal was filed with the Board subsequent to the March 30, 2022 Amended Complaint filed the California Central District Court, it is unclear to what extent this withdrawal of this participant from 20-1801GC and 20-1803GC impacts or is reflected in the litigation it is pursing in the California Central District Court.[26]

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 120 group cases, has identified ***numerous, material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board include, but are not limited to, the following.

1. *Providers With No Appeal Rights*.—In the following cases, there are providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue: Case Nos. 13-3612GC, 16-0371GC, 15 0802GC, 14-0366G, 14-0542GC, 15-0543GC, 14-1522GC, 14-1523GC, 14-2018GC, 14-2025GC, 14-2107GC, 14-2108GC,

[24] Through the application of 42 C.F.R. § 405.1837(a)(1), 42 C.F.R. § 405.1835(a)(3) applies to appeal request to directly add to a group.
[25] *See supra* note 5 (discussing what the Board's use of the term "substantive claim challenge" means).
[26] If Case Nos. 20-1801GC and 20-1803GC were to be remanded back to the Board, the Board would consider North Hawaii Community Hospital to have been effectively withdrawn, unless otherwise directed on remand, since participant withdrawals are self-effectuating under Board Rules. *See infra* note 28.

14-2930GC, 14-2931GC, 14-1768GC, 14-0416G, 14-3522G, 14-0416GC, 15-0800GC, 15-2680GC, and 13-3443GC.

2. *Invalid Appeals Due to Failure to Timely Appeal*.—Pursuant to 42 C.F.R. § 405.1835(a)(3), "[u]nless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be *no later than 180 days* after the date of receipt by the provider of the final contractor or Secretary determination." As the date of receipt is presumed to be 5 days after the date the final determination is issued,[27] an appeal request effectively must be filed with the Board within 185 days of the determination in order to be considered timely. The Board's preliminary review of jurisdiction has identified the following examples of participants that failed to timely appeal the group issue.

   a. In Case Nos. 15-3345G and 15-3346G, the Board is reviewing whether the appeal for Participant #2 Sonoma Valley, based on the non-issuance of an NPR, was timely filed.

   b. In Case Nos. 14-1522GC and 14-1523GC, the Board is reviewing the timeliness of Participant #11 Dallas Medical Center's appeal request because the proof of delivery included in the SoP is the Board Acknowledgement dated Friday, February 28, 2014 while the deadline for filing was Monday February 24, 2014.

   c. In both Case Nos. 19-2521G and 19-2524G, the Board is reviewing the timeliness of the appeal of Baton Rouge General Medical Center ("Baton Rouge"). Baton Rouge filed its appeal on August 27, 2019, based on the MAC's failure to timely issue an NPR under 42 C.F.R. § 405.1835(c) (2014). However, prior to filing that appeal, Baton Rouge had filed and the MAC accepted an amended cost report on April 16, 2019 suggesting that the August 27, 2018 appeal was premature.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants* ***in Excess of $500,000***.— There are a significant number of participants in these 120 groups for whom HRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though either ***HRS*** had ***previously withdrawn*** them from the relevant group case,[28] ***or*** the Board dismissed them and/or denied their transfer to the group appeal. Although the Board has not yet completed its review, the following examples from only 11 of the 120 cases alone demonstrate that HRS is ***improperly*** pursuing reimbursement ***in excess of $500,000.*** Such action on the part of HRS raises significant fraud and abuse concerns,[29] and the Board takes administrative notice that this is not an

[27] 42 C.F.R. § 405.1801(a) includes the definition for "date of receipt" and paragraph (1)(iii) of that definition explains that "[t]his [5-day] presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date."

[28] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

[29] Based on its preliminary review of just some of these cases, the Board fully expects to identify other situations where HRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of some of the SoPs that HRS refiled and is relying on for its consolidated EJR requests.

isolated concern. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[30] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings*. The following are recent examples of cases in which the Board has identified that HRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** has improperly pursued appeals that were prohibited duplicates of prior cases: Case Nos. 14-0369GC,[31] 14-3521,[32] 15-049G, 15-0554G,[33] 15-0605GC, 15-0606GC,[34] 14-3518G,[35] 15-1966GC,[36] 16-1224GC,[37] 19-0052,

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[30] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).

[31] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included St. Vincent Charity Medical Center on the final SoPs for Case Nos. 14-0369G because the Board had previously issued a determination (addressed to HRS) denying the request to transfer the Provider to that case more than 3 years earlier on dated May 25, 2015.

[32] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included Central Maine Medical Center on the final SoPs for Case Nos. 14-3521G because the Board had previously issued a determination (addressed to HRS) denying the request to transfer the Provider from Case No. 14-1712 to that group case more than 4 years earlier on April 10, 2014. Indeed, the April 10, 2014 determination shows that, even though HRS was not the designated representative in Case No. 14-1712, HRS had *improperly* attempted to add issues to that individual appeal and then transfer them to various optional groups, one of which was Case No. 14-3521G. As a result, the Board denied the transfer request to Case No. 14-3521G and dismissed the issue underlying that request.

[33] As part of an EJR determination dated March 29, 2019, the Board notified HRS that it had *improperly* included in the final SoPs for Case Nos. 15-0549G and 15-0554G Wooster Community Hospital for which the Board previously had issued a determination on November 25, 2015 dismissing the individual appeal as untimely and denying the request to transfer that Provider to the respective group appeals.

[34] As part of an EJR determination dated May 6, 2019, the Board notified HRS that:

1. It had *improperly* included Participant #20A because the Board previously had issued a determination on March 10, 2015 dismissing that Provider from its individual appeal under Case No. 15-0871 due to the failure to include a copy of the relevant cost report with its appeal as required under 42 C.F.R. § 405.1835(b) and Board Rules.
2. It had improperly included Participant #21 (Pampa Regional Medical Center) because "[o]n April 15, 2015, the HRS withdrew Pampa Regional Medical Center from both Case Nos. 15-0605GC and 15-0606GC and stated that the Group Representative '***will remove*** Pampa Regional Medical Center from the Schedule of Providers when submitted [to the Board].'" (Emphasis in original and quoting HRS withdrawal notice.)

[35] As part of an EJR determination dated April 1, 2019, the Board notified HRS that it had *improperly* included Central Maine Medical Center on the final SoP because "the Board previously ruled ***multiple*** times that [the Provider] did not properly add the Part C Days issue to its individual appeal and, thus, the Board has denied *multiple* times the Provider's request to transfer the issue to Case No. 14-3518G." (Emphasis in original and footnotes omitted.) In one of the footnotes appended to this statement, the Board noted that it had issued *three* ***separate*** denials dated April 10, 2014, July 10, 2014, and December 17, 2014.

[36] As part of an EJR determination dated April 1, 2019, the Board notified HRS that it had *improperly* included Providence Hospital on the final SoP for Case No. 15-1966GC because, on July 15, 2015, the Board had previously issued to HRS a dismissal of the Provider's individual appeal under Case No. 15-0481 for lack of jurisdiction and denied the Provider's request to transfer to Case No. 15-1966GC.

[37] In a jurisdiction determination, the Board dismissed Akron General Medical Center from the 2013 Cleveland Clinic CIRP group because the Provider was not owned or controlled by the Cleveland Clinic Foundation during that year and the Board had ***already*** granted EJR in a duplicate appeal (for the same issue and year) in the *optional* group under Case No. 17-0223G. As part of this dismissal, the Board noted that: (1) HRS had included the Provider as a direct add to the optional group (as a founding participant) approximately 3 weeks after HRS had already added the Provider to the CIRP group; and (2) notwithstanding, HRS had ***certified*** in the Provider's direct add to the optional

19-2149G, 19-2148G, 19-2147G, 19-2145G, 19-2144G, [38] 20-0154,[39] and 21-1780GC.[40] These examples highlight, *at a minimum*, HRS' reckless disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 650 open cases (of which the overwhelming majority are groups), HRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[41] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[42]

Especially egregious examples of HRS's failure to competently fulfill its responsibilities as a Provider Representative *in 11 of the instant 120 group cases* include:

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group that ***no appeal with the same group issue for the same year and same provider is pending with the Board***.

[38] On July 29, 2020, the Board notified HRS that it was denying the transfer of Adventist – Lodi from the individual case under Case No. 19-0052 to the 5 HRS optional groups under Case Nos. 19-2149G, 19-2148G, 19-2147G, 19-2145G, and 19-2144G because the Provider was commonly owned by Adventist and was required to be transferred to Adventist CIRP groups for the same issue and year. To this end, "[t]he Board remind[ed HRS] that, as a provider's representative, it is your responsibility, among other things confirm whether your client is subject to the CIRP group requirements in 42 C.F.R. § 405.1837(b)(1)(i); and if so, ensure that your client complies with those requirements (e.g., joining the relevant existing open CIRP group or establishing a new CIRP group if one had not been previously established)." Accordingly, "*the Board admonishe[d] HRS for its failure to identify the 5 CIRP group issues and further* ***instruct[ed] HRS to remove*** *Adventist – Lodi from the respective Schedules of Providers and supporting documentation for all five (5)* ***optional*** *group cases (i.e., 19-2149G, 19-2148G, 19-2147G, 19-2145G, and 19-2144G)*." (Emphasis in original.)

[39] By letter dated January 10, 2020, the Board issued notice to HRS that "*due to both [HRS's] mismanagement of [Case No. 20-01540 for the University Medical Center New Orleans] (as well as two related [2011 LSU] CIRP groups) and [HRS's] failure to provide complete and accurate information to the Board in response to the RFI, the Board [was] dismiss[ing] this case if,* ***within ten (10) days,*** *[HRS did] not properly transfer this case to the related CIRP groups and confirm whether these CIRP groups are complete*." By way of background, on March 19, 2018, HRS had filed an ***improper EJR request*** for those two related 2011 LSU CIRP groups because the CIRP groups were yet not fully formed and were waiting on the University Medical Center New Orleans for FY 2011. Accordingly, it was clear that HRS should have been aware that subsequently filing an EJR request for the University Medical Center New Orleans for FY 2011 on October 24, 2019 was improper. "These facts demonstrate that, ***if [HRS] had maintained an accurate inventory of your appeals and/or properly reviewed your records in response to the Board's RFI****, [HRS]u would have known to either directly add or transfer the Provider to the CIRP group, Case No. 14-2994GC, and known that immediately requesting EJR in the above captioned* ***individual*** *case9 was improper*." (Emphasis in original.)

[40] In Case No. 21-1780GC, HRS had filed a request for EJR and, on September 9, 2021, the Board notified HRS that more than 3 years earlier on June 13, 2018, the Board had already granted Prime Healthcare EJR for this same issue for the same year in the CIRP group under Case No. 18-0497GC *for which HRS was also the representative*. As such, the Board denied EJR and dismissed Case No. 21-1780GC because the group violated the CIRP regulation and was a prohibited duplicate under Board Rule 4.6. Finally, "***the Board remind[ed HRS]*** *that they have the responsibility to consult with their client and track and manage their cases and ensure they exercise due diligence prior to making filings*" and that "[***i***]***n particular, this responsibility includes consultation with the client prior to making the following certification*** *required for CIRP group appeals per Board Rule 12.10*." (Emphasis in original.)

[41] The Board has identified two SoPs where HRS noted withdrawals of a provider, namely the SoPs for the companion cases under Case Nos. 17-1236G and 17-1240G reflect the withdrawal of participant #3, Sonoma Valley Hospital for FY 2014. These SoPs were attached to the Grouping B consolidated EJR request dated January 17, 2022 and show an example of 2 SoPs where HRS *correctly* noted a provider that was previously withdrawn.

[42] *See Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party "explain in detail" its reason for non-compliance." (Emphasis added.)

a. In Case Nos. 14-0366G and 14-3519G, HRS *improperly* lists Participant #10 (Akron General Medical Center) in the final SoP as a participant because, on September 17, 2015, the Board issued a letter to HRS (as the representative in Case No. 13-0413) denying transfer of this Provider from its individual appeal under Case No. 13-0413 to the optional group under Case Nos. 14-0366G and 14-3519G. The 3-year period under 42 C.F.R. § 405.1885(b), and Board Rule 47, to reverse the Board's dismissal from Case No. 13-0412 has lapsed.[43] The Amount in Controversy ("AiC") for Participant #10 is $21,706 in *both* Case Nos. 14-0366 and 14-3519G.

b. In Case No. 14-2993GC, even though HRS withdrew Participant #2 (Medical Center of Louisiana at New Orleans) and Participant #4 (EA Conway Medical Center) on December 21, 2021, HRS *improperly* lists those providers as participants in the final SoP attached to the EJR request (filed just 8 days later on December 30, 2021). The AiC for Participant ##2 and 4 are $34,174 and $12,296 respectively.

c. In Case No. 15-0595GC, HRS *improperly* lists Pampa Regional Medical Center as Participant ## 19, 20A and 20B on the final SoP even though, on April 17, 2015, HRS had requested that Provider be "withdrawn from the Group" and represented that "HRS will remove Pampa Medical Center from the Schedule of Providers when submitted." The AiC for Participant ## 19, 20A, and 20B are $1,285, unlisted, and $1,505.

d. In Case No. 14-1768GC, HRS *improperly* lists Participant #1 (UH Richmond Medical Center) in the final SoP filed on January 11, 2022 because, earlier by letter dated May 16, 2018 (addressed to HRS), the Board dismissed this issue from the Provider's individual appeal under Case No. 13-2247 and denied transfer to Case No. 14-1768GC. The AiC for Participant #1 is $3,060. This also results in a prohibited single participant CIRP group under Case No. 14-1768GC.

e. In Case Nos. 19-2065G and 19-2067G, on January 7, 2021, HRS withdrew Arrowhead Regional Medical Center shortly after the MAC filed a Jurisdictional Challenge on December 23, 2020 requesting the Board to dismiss Arrowhead from the Group.[44] On January 11, 2021, the Board sent notice that the jurisdictional challenge regarding Arrowhead was moot given HRS' withdrawal of Arrowhead. Notwithstanding the withdrawal one year earlier (or the Board's notice), the SoP attached to the EJR request filed on January 17, 2022 continues to *improperly* list Arrowhead Regional Medical Center as a participant in Case Nos. 19-2065GC and

[43] The Board closed Case No. 13-0413 following its dismissal of the Medicaid fraction dual eligible days issue on September 17, 2015. As such, HRS filed the final SoP with Akron listed as a participant and EJR request in Case No. 14-0366G with that SoP attached thereto ***more than 6 years following*** the Board's dismissal and denial of Akron's transfer to Case No. 14-0366G.

[44] Also, earlier, by letters dated October 5 and 6, 2020, the MAC filed a jurisdictional challenges over Arrowhead in Case Nos. 19-2065G and 19-2067G based on its contention that Arrowhead had no appeal rights under 42 C.F.R. § 405.1835(a) since Arrowhead's appeal request was not timely (the appeal was submitted in 186 days) and under 42 C.F.R. § 405.1889 since the appeal was based on an revised NPR that did not adjust the dual eligible days at issue but rather only adjusted for a Worksheet S-10 review.

19-2067G and HRS did not file an updated final SoP in OH CDMS reflecting the withdrawal of Arrowhead. The AiC in Case Nos. 19-2065G and 19-2067G are $96,328 and $229,030, respectively.

f. In Case Nos. 15-0007GC and 15-0008GC, even though HRS withdrew Participant #14 (Pampa Regional Medical Center) on April 17, 2015, HRS continues to *improperly* list Pampa as a participant both on the final SoPs filed in these cases on February 17, 2022 as well as on the SoPs attached to the EJR request filed on February 27, 2022. The AiC listed on the SoP for Pampa in ***both*** cases is $4,931.

g. In Case No. 15-2680GC pertaining to the SSI fraction, HRS withdrew the original NPR appeal of Participant #1, Harlingen Medical Center ("Harlingen"), on December 21, 2018 and HRS used OH CDMS to make this filing which means that the withdrawal is readily confirmed. Notwithstanding this withdrawal, HRS continues to *improperly* list Harlingen's original appeal as Participant No. 24 with an AiC of $47,320. It also is unclear why Harlingen also remains listed as Participant #25 based on its revised NPR and an AiC of $2,989.[45] Moreover, HRS has failed to address whether it is appropriate for Harlingen to continue to participate in the companion case under Case No. 15-2681GC pertaining to the Medicaid fraction as Participant ## 24 and 25 with AiCs of $47,320 and $2,989, respectively; and, in particular, it raises issues about whether, following the withdrawal of Harlingen from Case No. 15-2680GC, the Provider continues to have the same factual or legal question common to each of the other participants in Case No. 15-2680GC and, in turn, whether the ***full*** legal framework and questions posed in the EJR request could continue be applicable to Harlingen.

h. HRS *improperly* submitted an EJR request for the ***closed*** case under Case No. 13-3496GC. Roughly 5 years earlier, by letter dated January 17, 2017, the Board dismissed Case No. 13-3496GC for failure to timely file a preliminary position paper. This 2007 LSU CIRP group pertained to the Medicaid fraction portion of the dual eligible days issue and there is a separate 2007 LSU CIRP relating to the SSI fraction portion of the dual eligible days issue under Case No. 15-0802GC.[46] Notwithstanding the CIRP group having been dismissed almost 5 years prior, and OH CDMS showing the "status" of Case No. 13-3496GC as being "closed," HRS filed ***in OH CMDS*** a request for EJR for Case No. 13-3496GC claiming an aggregate amount in controversy of $22,706 *without acknowledging the closed status or requesting reopening or reinstatement*. By letter dated January 4, 2022, the Board notified HRS that the EJR request as it related to Case No. 13-3496GC was "***void*** in the first instance"[47] because the Board had "dismissed the subject CIRP group almost 5 years ago on January 17,

[45] Regardless, the Board is also reviewing whether Harlingen had a right under 42 C.F.R. § 405.1889(b) to appeal the group issue in Case No. 15-2680GC.

[46] By letter dated October 30, 2014, HRS requested that the Board grant bifurcation of the "SSI Fraction/dual Eligible Days sub-issue[]" from Case No. 13-3495GC. In making that request, HRS specifically recognized "[f]or . . . the Medicaid Fraction/Dual Eligible Days sub-issues, HRS already established groups. *See* . . . HRS LSU 2007 DSH Payment Dual Eligible Days CIRP Group, PRRB Case Number 13-3496GC." The Board granted that bifurcation to establish Case No. 15-0802GC for the SSI fraction portion of the dual eligible days issue.

[47] (Emphasis added.)

2017 for failure to timely file a preliminary position paper (which incidentally is more than two years beyond the 3-year period in which a case can potentially be reinstated under Board Rule 47)." Notwithstanding, it is the Board's understanding that HRS is pursuing the merits of this case (which relates to the Medicaid fraction portion of the issues stated in the EJR request) in federal district court.[48] If HRS is in fact pursuing the Medicaid fraction portion of the EJR request as captured in Case No. 13-3496GC, then that pursuit would have ***no creditable*** basis or merit since, as previously noted, the 3-year period to request the Board to reinstate or reopen has lapsed per 42 C.F.R. § 405.1885(b) and Board Rule 47.

4. *Unauthorized Representation of Participants*.— The Board has also identified situations where HRS ***failed*** to obtain proper authorization from the provider to be a participant in the relevant group. For example, in both Case Nos. 15-0595GC and 15-0604GC, HRS failed to have a proper letter of representation on file authorizing it to file direct-add appeal requests for the following 2 participants to Case Nos. 14-0494GC and 15-0604GC: Participant #15, Garden City Hospital ("Garden City"), whose direct add request was filed on or about December 30, 2016; and Participant #17, St. Mary's Hospital, Passaic ("St. Mary's Passaic") whose direct add request was filed on or about May 16, 2016. Each of the final SoPs with supporting jurisdictional documentation filed for these cases lists participants through Participant 25B, and the letter of representation included behind Tab H for all the ***other*** participants consisted of a cover letter dated June 13, 2014 from Michael Bogert, the Vice President of Corporate Finance at Prime Healthcare where the "RE:" line stated:

> RE: APPOINTMENT OF DESIGNATED REPRESENTATIVE
> System Name: Prime Healthcare Management, Inc.
> Provider Numbers: Various – See Attached Listing
> Fiscal Years: Various (Fiscal Years 2001 through 2015)
> Lead MAC: Noridian Heathcare Solutions, LLC

The referenced listing was a single page attachment entitled "List of Prime Healthcare Management, Inc. Providers" and consisted of 24 providers where the relevant fiscal years varies from provider to provider (*e.g.*, Desert Valley is authorized for all 15 years, FYs 2001 through 2015, while Sherman Oaks Hospital is only authorized ***only*** for 10 years, FYs 2006 through 2015, and Harlingen Medical Center is authorized ***only*** for 6 years, FYs 2010 through 2015). Significantly, neither Garden City nor St. Mary's Passaic are listed on the attached list of 24 Prime Healthcare providers. In contrast, the letter of representation included in the SoPs of these two CIRP groups for Garden City and St. Mary's Passaic consists of the *exact* ***same*** cover letter (*e.g.*, same date, same re: line, same text, same signature and signatory, and same cc's) but the attached list of providers is *strikingly* ***different*** in that it consists of 39 providers (as opposed to 24) and does not specify which fiscal years from 2001 to 2015 that the authorization applies (*e.g.*, the authorization for Harlingen Medical Center is somehow no longer restricted to FYs 2010 through 2015 and would be authorized for FYs 2001 through 2015 under this

[48] Exhibit A attached to the March 30, 2022 Amended Complaint includes Case No. 13-3496GC and, as such, it appears that HRS is pursuing the merits of the EJR request as it relates to this case in federal district court.

attachment). Indeed, the Board suspects that most if not all of the additional 15 providers listed on this new attachment were neither owned nor controlled by Prime Healthcare during the 2001 to 2015 timeframe (in whole or in part)[49] and that, upon review of its files, this new attachment was originally appended to a cover letter from Prime dated July 11, 2016 as shown in the direct add request for St Mary's Regional Medical Center filed by HRS in Case No. 15-0604GC on November 28, 2016. Accordingly, the Board would reject the authenticity of the letter of representation included for Garden City and St. Mary's Passaic and dismiss them from Case Nos. 15-0595GC and 15-0604GC.

5. *Failure to meet minimum $50,000 AiC requirement for a group appeal*. —As explained in 42 C.F.R. § 405.1839(b), "[i]n order to satisfy the amount in controversy [or AiC] requirement . . . for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000." Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." The following cases are examples of cases where the Board is reviewing whether the AiC requirement is met.

   a. Both Case Nos. 15-0542GC and 15-0543GC have only 2 participants and each case fails to meet the minimum $50,000 amount in controversy required for a group in that the SoP for each case lists a total AiC of $9,092 (2,878 for one provider and 6,214 for the other provider). Significantly, both participants were direct adds and neither provider would meet the minimum $10,000 AiC required for an individual appeal.

   b. Case Nos. 16-1317GC and 16-1318GC are companion 2013 CIRP group cases involving UHHS where one appeal addresses the SSI fraction and the other the Medicaid fraction. The final SoP filed on February 17, 2022 in each case only listed 3 participants and a total AiC list on the final SoP of $21,531 in each case. Thus, each UHHS 2013 CIRP group, though fully formed, failed to meet the minimum $50,000 AiC required for a group. By letter dated March 18, 2022, the Board noted this "impediment with regard to jurisdiction" and proposed expansion of the UHHS 2014 CIRP groups under Case Nos. 17-1095GC and 17-1096GC to include 2013 and then consolidate Case Nos. 16-1317GC and 16-1318GC into them, respectively. To this end, the Board required HRS to respond *within 15 days on the proposed actions*, and noted that, "as jurisdiction is a prerequisite to consideration of an EJR request, this [RFI] necessarily affects the 30-day period for responding to the EJR requests in these cases." On March 29, 2022, HRS responded and requested that the Board instead expand the UHHS 2012 CIRP groups under Case Nos. 15-2629GC and 15-2630GC and consolidate them with Case Nos. 16-1317GC and 16-1318GC respectively because these 2 cases were also part of the same consolidated EJR request filed on February 27, 2022. Significantly, HRS did ***not*** dispute the Board's characterization of

[49] For example, it is the Board's understanding that Prime Healthcare did not own or otherwise control Suburban Community Hospital until 2016 and Lake Huron Medical Center, Saint Clare's Hospital, and Riverview Medical Center until 2015. If true, all of these acquisitions would have occurred after the September 10, 2014 execution date.

> failure to meet the $50,000 AiC as an "impediment with regard to jurisdiction" or the Board's position that jurisdiction is a prerequisite to the beginning of the 30-day EJR determination period. The Board, by letter dated April 4, 2022: (1) granted HRS' request, expanded Case Nos. 15-2629GC and 15-2630GC to include CY 2012, consolidated them with Case Nos. 16-1317GC and 16-1318GC, respectively, and issued a consolidation of these cases with another case; (2) required HRS to file an updated SoP with supporting jurisdictional documentation for Case Nos. 15-2629GC and 15-2630GC to reflect the consolidation; and (3) confirmed that it "will take no further action on the EJR in the surviving cases 15-2629GC and 15-2630GC, until the record is complete and the updated SoPs have been submitted." On April 7, 2022, HRS filed the updated SoPs in Case Nos. 15-2629GC and 15-2630GC.[50]

6. *Apparent Abandonment of Providers*.—It appears that HRS has abandoned 3 participants in Case No. 15-0595GC, namely Participants 8A and 8B (San Dimas Community Hospital, FYE 12/31/2012 based on an appeal for failure to issue an NPR and an appeal of the original NPR) and Participant #19 (Lower Bucks Hospital FYE 12/31/2012 based on an appeal for failure to issue an NPR). Specifically, the final SoP for Case No. 15-0595GC, filed on March 1, 2021, included participants starting at Participant 1A and ending with Participant 25B and included San Dimas as Participants ##8A and 8B and Lower Bucks as Participant #19. In contrast, the SoP attached to the EJR request filed in Case No. 15-0595GC on December 29, 2021 only included participants through 23B and did ***not*** include either San Dimas or Lower Bucks. Without additional information, the Board would have to assume those providers have been withdrawn or otherwise abandoned.

7. *The Compliance of Commonly Owned/Controlled Providers with the CIRP group requirements*.—Pursuant to 42 C.F.R. § 405.1837(b)(1):

> 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

[50] The SoP attached to the EJR for both Case No. 15-2629GC and Case No. 15-2630GC only lists 2 participants (UH Regional Hospitals and UH Case Medical Center) and each case only concerned one fiscal year, namely FY 2012. However, by letter dated March 18, 2022, the Board requested comments on whether to expand CIRP groups for FY 2014 under Case Nos. 17-1095GC and 17-1096GC to include FY 2013 for UHHS as the 2013 CIRP groups under Case Nos. 16-1317GC and 16-1318GC were fully formed but only failed to meet the minimum $50,000 amount in controversy required for a group. On March 29, 2018, HRS responded and requested that the Board instead combine the 2013 CIRP group under 16-1317GC and 16-1318GC with those for FY 2012 under Case Nos. 15-2629GC and 15-2630GC because HRS had requested EJR for both sets of cases in the same EJR request dated February 27, 2022 and it would "allow the continuation of the EJR request." However, HRS failed to disclose in its March 29, 2018 response to the Board that it was filing suit in the U.S. District Court for the Central District of California the next day on March 30, 2022. Due to HRS' failure to disclose this information, the Board continued its work on these cases and, by letter dated April 4, 2022, consolidated the 2012 and 2013 CIRP groups and characterized the EJR request as "pending" and noted that the March 16, 2022 Alert 19 letter previously extended the deadlines." The Board required the representative to file a new SoP within 30 days to reflect the consolidation. HRS filed this updated SoP on April 7, 2022 and, again, failed to inform the Board of its litigation filed earlier on March 30, 2022.

> the amount in controversy is $50,000 or more in the aggregate, ***must*** ***bring the appeal as a group appeal***.[51]

In these situations, the commonly owned/controlled providers must establish a common issue related party ("CIRP") group. The following are examples of participants in optional groups that the Board has, to date, identified as being potentially subject to the mandatory CIRP group requirements.

a. Case Nos. 15-3345G and 15-3346G contain participants that appear to be commonly owned or controlled and potentially subject to the mandatory CIRP group requirements for the fiscal year at issue (*see, e.g.*, #5 Queens, #3 Prime East, #9 EMH, #11 Landmark Prime, and #12 Warsaw Ascension).

b. In the 2016 optional groups under Case Nos. 19-2065G and 19-2067G, the Board issued a "Show Cause Order for Dismissal of Optional Group Participant" on April 28, 2022 because one of the participants, Akron General Medical Center ("Akron"), may be subject to dismissal for failure to comply with the mandatory CIRP group regulations.[52] In issuing the Show Cause Order, the Board noted that the Cleveland Clinic already had two 2016 CIRP groups of the same issues pending before the Board in the ***fully formed*** CIRP groups under Case Nos. 20-1711GC and 20-1713GC and that Akron is a participant in the Cleveland Clinic CIRP groups that HRS formed ***one year earlier*** for 2015 under Case No. 18-1593GC ***and*** for 2016 under Case No. 19-0426GC. Consequently, pursuant to its authority under 42 C.F.R. § 405.1868(b)(2), the Board required that HRS "confirm whether, or not, [Akron] is *owned* ***or controlled*** by the Cleveland Clinic Foundation." On May 4, 2022, HRS responded by alleging that "[Akron] was not *owned or operating* under Cleveland Clinic Foundation but was reporting under Akron General Health System up through and including the 2017 cost year" and that "[i]t wasn't until 2018 that Akron began *reporting* under Cleveland Clinic Foundation as it's parent company." Significantly, HRS' response failed to address: (1) whether the Cleveland Clinic Foundation ***controlled*** Akron General Health System prior to 2018 as suggested by the fact that HRS has included Akron in Cleveland Clinic CIRP groups for both the prior fiscal year (2015) and the current fiscal year (2016);[53] and (2) the fact that HRS had filed an amended complaint in federal district court earlier on March 30, 2022 regarding the merits of its EJR request in Case Nos. 19-2065G and 19-2067G in order to join ongoing litigation under Case No. 22-cv-00989 established by QRS.

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[51] (Emphasis added.)

[52] Significantly, the representative authorization letter was generic to Cleveland Clinic Health System stating that "Cleveland Clinic Health System hereby formally appoints [HRS] as its' designated representative for fiscal years 2010 to 2019 for the Cleveland Clinic Foundation with respect to the attached list of Provider Numbers. The attached list was entitled "Cleveland Clinic Health System List of Providers and listed 11 providers which included Akron General Medical Center. The year at issue 2016 is in the middle of the fiscal years 2010 to 2019 authorized in the letter as pertaining to the Cleveland Clinic Health System Providers.

[53] Moreover, publicly available information suggests that the Cleveland Clinic Foundation acquired a controlling interest in the Akron General Health System in 2015. *See, e.g., https://www.justice.gov/opa/pr/northern-ohio-health-system-agrees-pay-over-21-million-resolve-false-claims-act-allegations*.

8. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant portion of the participants in these 120 groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[54] The Board expects it would identify additional issues if it were to complete its jurisdictional review. For example, in Case Nos. 14-0366G and 14-3519G, the Board is reviewing to dismiss Participant #12, Robinson Memorial, as this participant transferred into this group from its individual appeal but its individual appeal did not include the issue that is the subject of these groups and EJR request.

9. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues; one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation. Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies. Examples include:

    a. In Case No. 15-0802GC for LSU, the Board is reviewing whether the EJR request should be denied because it is beyond the scope of the group issue statement.

    b. In Case No. 15-0800GC for FMOLHS, the Board is reviewing whether the EJR request should be denied, in whole or in part, because the EJR request addresses both fractions in the DSH computation, the group issue statement only encompasses one fraction in the DSH computation, and there is a FMOLHS companion case pending for the other fraction under Case No. 13-3443GC that was ***not*** included in the instant EJR request.

    c. In Case No. 20-0259GC for Lafayette General, the Board is reviewing whether the EJR request should be denied, in whole or in part, because the EJR request addresses both fractions in the DSH computation, the group issue statement only encompasses one fraction in the DSH computation, and there is a Lafayette General companion case pending for the other fraction under Case No. 20-0261GC that was ***not*** included in the instant EJR request. (Lafayette).

[54] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.

10. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[55] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The 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.[56] The Board is reviewing whether the Providers' consolidated EJR requests filed for Groupings A, B and C are challenging multiple interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[57]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[58]). If true, it raises immediate jurisdictional problems of whether the additional challenges are *properly* part of the relevant groups[59] and, if true, resolving: (1) whether each of the participants properly appealed additional issues and, as relevant, whether it requested transfer of those additional issues to the group; and (2) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2).[60] A critical aspect of

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[55] *See* 42 C.F.R. §§ 405.1842(a), 405.1842(f); 73 Fed. Reg. 30190, 30212 (May 23, 2008) (in response to comment that "the Board should have the authority to handle more than one question of fact or law in a group appeal" because "sometimes there is more than one disputed fact or question of law pertaining to a single item on the cost report" where "[a] common example of this is the [DSH] adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary affirmed that [t]he regulations at § 405.1837(a)(2) . . . specify that a group appeal involve a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group" and that "[w]hat constitutes an appropriate group appeal issue in a given case will be determined by the Board."). The Board further notes that 42 C.F.R. § 405.1839(b) (underline and bole emphasis added) states the following in relevant part:

> (b) *Group appeals*. (1) In order to satisfy the amount in controversy requirement under § 405.1837(a)(3) of this subpart for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000.
> (2) *Aggregation of claims*. (i) For purposes of satisfying the amount in controversy requirement, group members are **not allowed to aggregate claims involving different issues**.
> (A) A group appeal must involve a **single** question of fact or **interpretation** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

[56] (Emphasis added.)

[57] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Services*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).

[58] *Becerra v. Empire Health Foundation*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[59] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.

[60] Indeed, the Board is aware that, notwithstanding the fact that it is pursing the merits of its EJR requests in federal district court, it subsequently filed preliminary position papers in the following case and that this position papers include not just the *Empire* issue but also the SSI eligibility code issue embodied in PRRB Dec. No. 2017-D11:

- On April 11, 2022 for Case Nos. 15-1890GC, 15-1968GC, 14-1526GC, 14-2992GC, and 14-3281GC.
- On April 13, for Case No. 14-1668GC.

> the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years.

Notwithstanding the above jurisdictional issues and concerns, HRS made clear with the March 30, 2022 filing of the Amended Complaint in federal district court that it has abandoned the Board's jurisdictional review process (as discussed above). However, to date, HRS still has not notified the Board that it filed the amended complaint in federal court to pursue the merits of its EJR requests in Groupings A, B, and C.

The delay in learning of HRS' abandonment of the Board's jurisdictional process by virtue of the OAA request for records has caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 569 participants in the 120 group cases.[61] More concerning is HRS' attempt to undermine, and bypass, the Board's regulatory and statutory duty to conduct a complete and thorough jurisdictional review process for all of the participants in these cases. HRS essentially self-declared that the participants in these groups have a right to pursue EJR in federal district court (regardless of whether the Board has jurisdiction over such providers, including instances of previously dismissed or withdrawn providers). If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.[62]

C. Effect of HRS' Filing of the Amended Complaint on the 120 Group Cases

42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may <u>not</u> conduct any further***

- On May 13, 2022, for Case Nos. 15-0008GC, 15-2402GC, 15-2629GC, and 17-0438GC.

[61] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and was then processing many EJR requests involving multiple thousands of participants. As of April 1, 2022, ***in addition to*** *the 120 cases covered in this notice*, the Board had 178 cases with EJR requests pending. On or after April 1, 2022, EJR requests were filed for an additional 218 cases in April, 54 in May and 72 in June. As these cases were primarily group cases, they involved thousands of participants in the aggregate.

[62] As explained *supra*, a partial review of just 11 of the 120 group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $500,000 in controversy on the related SoPs.

> ***proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[63]

This regulation ***bars any further Board proceedings*** in these 120 group cases, including proceedings on pre-requisite jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 120 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[64] and the May 23, 2008 final rule[65] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[66]

The discussion in the final rule includes additional guidance on 42 C.F.R. § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However,

[63] (Emphasis added.)
[64] 69 Fed. Reg. 35716 (June 25, 2004).
[65] 73 Fed. Reg. 30190 (May 23, 2008).
[66] 69 Fed. Reg. at 3572

> we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[67]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that HRS' March 30, 2022 filing of the Amended Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the consolidated EJR requests for Groupings A, B, and C as filed, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that HRS created the confusion surrounding the status of these cases at the Board. HRS' filing of the Amended Complaint was not made in good faith as it ignores both the Board's ruling in its Scheduling Order ***and*** the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[68] HRS had a duty to communicate early and in good faith with the Board and the opposing party (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences.

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[67] 73 Fed. Reg at 30214-15.

[68] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), HRS, as the Providers' representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 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/ReviewBoards/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;
> - 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.[69]

Indeed, the following inaction on HRS' part belies any claim that proceedings before the Board have been exhausted:

1. For Groupings B and C, HRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' motion to extend the Medicare Contractor's time to file

[69] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board. Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

jurisdictional challenges. Moreover, HRS' objection to FSS' extension request for Grouping A did not discuss or mention the 30-day period, after a Board finding of proper jurisdiction, in which the Board has to process a complete and proper EJR request.

2. HRS failed to notify the Board of its objection to the Board's ruling on the extension, and the associated Scheduling Order. HRS' failure to file and preserve its objection to the Board's ruling and Scheduling Order violates HRS' obligations under Board Rules 1.3, 5.2, and 44, and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[70]

3. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[71] and Board Alert 19. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. The Board was not able to operate normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Orders for Groupings A, B, and C to memorialize, and effectuate, the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. HRS failed to notify the Board of its objection to the Board Scheduling Orders. HRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, HRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[72] or take other actions, ***prior to*** the HRS filing its March 30, 2022 Amended Complaint. HRS' failure to provide proper notice allowed the 30-day EJR review deadline, as alleged by HRS to be established in 42 U.S.C. § 1395oo(f)(1) (that HRS alleges in its litigation the Board missed), to pass, and, under

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[70] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule it was stated 'the exception is no longer necessary, if you have made your point clear to the court below. ' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * * , so the rule requires him to disclose the grounds of his objections fully to the court. ' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

[71] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).

[72] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 5, 2004 proposed rule. *See supra* notes 66, 67 and accompanying text.

HRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[73]

4. In its Scheduling Orders, the Board set forth its process for conducting jurisdictional review. For Groupings A and B, in addition to specifying time for the Medicare Contractors to file jurisdictional challenges and the Providers to respond to those challenges, the Board included the following directive to the parties to supplement the record in these group cases "*to ensure the record before it in these group cases is* ***complete***"[74]:

> The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases*.

HRS blatantly disregarded the Board's directive to supplement the record relative to jurisdiction.

5. HRS' failure to promptly notify the Board that it had joined the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of HRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). The following circumstances make it clear that HRS had an affirmative obligation to notify the Board of the Complaint being filed, and that HRS should have been aware of that affirmative obligation:

   a. The Board, in its Scheduling Orders, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Orders directed both parties to submit certain jurisdictional related information, over a 90-day time frame.

   b. Both the Board and the Medicare Contractors were acting in reliance on the authority of those Scheduling Orders.

   c. Notwithstanding its March 30, 2022 joinder of the litigation in the California Central District Court, HRS subsequently filed preliminary position papers ("PPPs) in the following cases and included *disingenuous* "Good Faith"

[73] *See supra* note 70 (discussing how the FRCP supports the Board's position).
[74] (Emphasis added.)

statements that "[d]ue to the [insert name of issue[75]], I assume we cannot seek a joint settlement or an agreement and will need to proceed to the PRRB":

- On April 11, 2022 for Case Nos. 15-1890GC, 15-1891GC, 15-1968GC, 15-1969GC, 14-1526GC, 14-1593GC, 14-2992GC, 14-2993GC, 14-3281GC, and 14-3276GC.[76]

- On April 13, 2022, for in Case Nos. 14-1668GC and 14-1669GC.[77]

- On May 13, 2022 for Case Nos. 15-0007GC, 15-0008GC, 15-2402GC, 15-2403GC, 15-2629GC, 15-2630GC, 17-0438GC, and 17-0439GC.[78]

In this regard, Board Rule 25.3 specifies "[t]he Board requires the parties file a complete preliminary position paper that includes . . . a statement indicating ***how a good faith effort to confer was made*** in accordance with 42 C.F.R. § 405.1853." Notwithstanding, HRS failed to disclose that, on March 30, 2022, it had joined the litigation in the California Central District Court.

These circumstances make clear that HRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, HRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on, or about, March 30, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay, or cease work on the 120 group cases and the underlying 569 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by HRS and other representatives. Indeed, HRS' failure to notify the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by HRS to benefit current and subsequent EJR requests that HRS filed on behalf of other providers ***or*** EJR requests for the same issue filed by QRS.[79] In this regard, it is the Board's understanding that QRS had, on February 14, 2022, established the ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that HRS *joined* QRS in that lawsuit when an Amended Complaint was filed on March 30, 2022 incorporating the instant EJR requests for Groupings A, B, and C into that lawsuit. For a point of reference and context for these serious violations by HRS and QRS, the Board has

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[75] The Good Faith statements referenced the group issue in the case as either the "DSH Payment Dual Eligible Days issue," "DSH Medicaid Fraction Dual Eligible Days issue" or "DSH SSI Fraction Dual Eligible Days issue."
[76] Attached to each PPP was a Good Faith Statement dated April 1, 2022.
[77] Attached to each PPP was a Good Faith Statement dated April 1, 2022.
[78] Attached to each PPP was a Good Faith Statement dated May 1, 2022.
[79] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

included as **Appendix D** a copy of the closure letter it issued in those 80 QRS group cases. Finally, it is the Board's understanding that HRS filed another Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering other EJR requests but without completing the jurisdictional review process and without notice to the Board.[80]

It is clear the Providers are pursuing the merits of their cases in Groupings A, B, and C as part of the lawsuit. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[81] However, the Board cannot permit HRS' reckless disregard for its ***basic*** responsibilities and due diligence, as a representative appearing before the Board (including but not limited to failure to track and account for withdrawn/dismissed providers), its abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded to it for further proceedings*, the Board will complete its jurisdictional review and weigh the severity of HRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[82]

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[83] Accordingly, the Board hereby closes these cases and removes them from the Board's docket.[84] No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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

For the Board:

9/23/2022

X Clayton J. Nix

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

[80] The Board will be addressing the status of these other cases under separate cover shortly.
[81] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.
[82] The Board's planed actions are consistent with those planned for QRS as laid out in Appendix.
[83] In order for the Board to have jurisdiction over a group, it can only have one issue as noted in *supra* note 55, 81 and accompanying text.
[84] *See supra* note 5.

Enclosures:

Appendix A – Case List for Grouping A
Appendix B – Case List for Grouping B
Appendix C – Case List for Grouping C
Appendix D – June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Danielle Decker, NGS
Cecile Huggins, Palmetto GBA
Byron Lamprecht, WPS
Wilson Leong, FSS
Jacqueline Vaughn, OAA

APPENDIX A

Grouping A – List of the 63 Group Cases Covered by the Consolidated Request for EJR Filed on December 29, 2021

13-3115GC	HRS FMOLHS 2008 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0604GC	HRS Prime Healthcare 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0804GC	HRS LSU 2008 SSI Fraction Dual Eligible Days CIRP
15-1890GC	HRS Willis-Knighton Health Systems 2012 DSH SSI Fraction Dual Eligible Days CIRP
15-1891GC	HRS Willis-Knighton Health Systems 2012 DSH Medicaid Fraction Dual Elig. Days CIRP
15-1968GC	HRS SCHS 2012 DSH SSI Fraction Dual Eligible Days CIRP
15-1969GC	HRS SCHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
16-1743GC	HRS FMOLHS 2013 DSH Medicaid Fraction Dual Eligible Days CIRP
15-1980GC	HRS ECHN 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-1981GC	HRS ECHN 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
15-2335GC	HRS UHHS 2010 DSH SSI Fraction Dual Eligible Days CIRP
15-2482GC	HRS FMOLHS 2011 DSH SSI Fraction Dual Eligible Days CIRP
15-2483GC	HRS FMOLHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
15-3345G	HRS 2013 DSH SSI Fraction Dual Eligible Days Group
15-2336GC	HRS UHHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP
16-1742GC	HRS FMOLHS 2013 DSH SSI Fraction Dual Eligible Days CIRP
17-0070GC	HRS DCH 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
17-0071GC	HRS DCH 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
15-3346G	HRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
17-0225G	HRS 2013 DSH Medicaid Fraction Dual Eligible Days Group II
17-0226G	HRS 2013 DSH SSI Fraction Dual Eligible Days Group II
17-0732G	HRS 2006 DSH SSI Fraction Dual Eligible Days Group II
13-3264GC	HRS SCHS 2008 DSH Payment Dual Eligible Days CIRP Group
13-3304GC	HRS FMOLHS 2009 DSH Payment Dual Eligible Days
13-3443GC	HRS FMOLHS 2007 DSH Payment Dual Eligible Days CIRP Group
13-3464GC	HRS LSU 2008 DSH Payment Dual Elig Days CIRP Group
13-3496GC	HRS LSU 2007 DSH Payment Dual Eligible Days CIRP Group[85]
17-0734G	HRS 2006 DSH Medicaid Fraction Dual Eligible Days Group II
17-0831GC	HRS Prime Healthcare 2005 DSH SSI Fraction Dual Eligible Days CIRP
17-0832GC	HRS Prime Healthcare 2005 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0203GC	Eastern Connecticut HN CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0216GC	Eastern Connecticut HN CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Grp
13-3612GC	HRS Willis-Knighton Health Systems 2008 DSH Payment Dual Eligible Days
14-0366G	HRS 2007 DSH Payment Medicaid Fraction Dual Elig Days Group
14-1059GC	HRS SCHS 2007 DSH SSI Fraction Dual Eligible Days CIRP
14-1061GC	HRS SCHS 2007 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1526GC	HRS Willis Knighton Health Systems 2007 DSH SSI Fraction Dual Eligible Days CIRP
14-1593GC	HRS Willis Knighton Health Systems 2007 Medicaid Fraction Dual Eligible Days CIRP
15-0802GC	HRS LSU 2007 SSI Fraction Dual Eligible Days CIRP
14-1668GC	HRS SCHS 2009 DSH SSI Fraction Dual Eligible Days CIRP
14-1669GC	HRS SCHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP

[85] By letter dated January 17, 2017, the Board dismissed Case No. 13-3496GC for failure to timely file a preliminary position paper.

14-2018GC	HRS Willis-Knighton Health Systems 2009 DSH SSI Fraction Dual Elig. Days CIRP
14-2025GC	HRS Willis-Knighton Health Systems 2009 DSH Medicaid Fraction Dual Elig. Days CIRP
14-2992GC	HRS LSU 2011 DSH SSI Fraction Dual Eligible Days CIRP
14-2993GC	HRS LSU 2011 DSH Medicaid Fraction Dual Eligible Days CIRP
14-3194GC	HRS SCHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3281GC	HRS SCHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3519G	HRS 2007 DSH SSI Fraction/Dual Eligible Days Group
14-3195GC	HRS SCHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0280GC	HRS WKHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3276GC	HRS SCHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0308GC	Lafayette General Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0310GC	Lafayette General Health CY 2015 DSH Medicaid Fraction Dual Elig. Days CIRP Group
19-1269G	HRS CY 2013 DSH SSI Fraction Dual Eligible Days 3 Group
19-1271G	HRS CY 2013 DSH Medicaid Fraction Dual Eligible Days 3 Group
15-0285GC	HRS WKHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0595GC	HRS Prime Healthcare 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0337GC	HRS WKHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0338GC	HRS WKHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0369GC	HRS SCHS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0371GC	HRS WKHS 2008 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0542GC	HRS LSU 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0543GC	HRS LSU 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group

APPENDIX B

Grouping B – List of the 40 Group Cases Covered by the Consolidated Request for EJR Filed on January 17, 2022

14-0416G	HRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
14-0860GC	HRS FMOLHS 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-0864GC	HRS FMOLHS 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1276GC	HRS LSU 2009 DSH SSI Fraction Dual Eligible Days CIRP
14-1277GC	HRS LSU 2009 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1522GC	HRS Prime Healthcare 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-1523GC	HRS Prime Healthcare 2009 DSH Medicaid Fraction Dual Eligible Days CIRP
14-1768GC	HRS UHHS 2006 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-1769GC	HRS UHHS 2006 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2107GC	HRS LSU 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2108GC	HRS LSU 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2310GC	HRS UHHS 2009 DSH SSI Fraction Dual Eligible Days CIRP Group
14-2311GC	HRS UHHS 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-2930GC	HRS Prime Healthcare 2010 DSH Medicaid Fraction Dual Eligible Days CIRP
14-2931GC	HRS Prime Healthcare 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
14-3522G	HRS 2006 DSH SSI Fraction Dual Eligible Days Group
15-0671GC	HRS FMOLHS 2012 DSH SSI Fraction Dual Eligible Days CIRP Group
15-0672GC	HRS FMOLHS 2012 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-0800GC	HRS FMOLHS 2007 SSI Fraction Dual Eligible Days CIRP
15-2188GC	HRS UHHS 2011 DSH SSI Fraction Dual Eligible Days CIRP Group
15-2189GC	HRS UHHS 2011 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-2656G	HRS 2011 DSH SSI Fraction Dual Eligible Days Group II
15-2657G	HRS 2011 DSH Medicaid Fraction Dual Eligible Days Group II
17-1236G	HRS 2014 DSH Medicaid Fraction Dual Eligible Days Group
17-1240G	HRS 2014 DSH SSI Fraction Dual Eligible Days Group
19-0049G	HRS CY 2015 DSH SSI Fraction Dual Eligible Days Group
19-0051G	HRS CY 2015 DSH Medicaid Fraction Dual Eligible Days Group
19-0129GC	HRS Sisters of Charity Health CY 2015 DSH SSI Fraction Dual Eligible Days
19-0131GC	HRS Sisters of Charity Health CY 2015 DSH Medicaid Fraction Dual Eligible
19-2065G	HRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2067G	HRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2521G	HRS CY 2017 DSH SSI Fraction Dual Eligible Days Group
19-2524G	HRS CY 2017 DSH Medicaid Fraction Dual Eligible Days Group
19-2527GC	HRS Willis-Knighton CY 2017 DSH SSI Fraction Dual Eligible Days CIRP
19-2529GC	HRS Willis-Knighton CY 2017 DSH Medicaid Fraction Dual Eligible Days
19-2644GC	HRS Sisters of Charity Health CY 2016 DSH SSI Fraction Dual Eligible Days
19-2646GC	HRS Sisters of Charity Health CY 2016 DSH Medicaid Fraction Dual Eligible
20-0259GC	HRS Lafayette General Health CY 2016 DSH SSI/Medicaid Dual Eligible Days
20-1801GC	HRS The Queens Health Systems CY 2017 DSH SSI Fraction Dual Eligible[86]
20-1803GC	HRS The Queens Health Systems CY 2017 DSH Medicaid Fraction Dual Eligible[87]

[86] *See supra* note 26 and accompanying text.
[87] *See supra* note 26 and accompany text.

APPENDIX C

Grouping C – List of the 17 Group Cases Covered by the Consolidated Request for EJR Filed on February 27, 2022

15-0007GC	HRS Prime Healthcare 2011 DSH Medicaid Fraction Dual Eligible Days Group
15-0008GC	HRS Prime Healthcare 2011 DSH SSI Fraction Dual Eligible Days Group
15-2680GC	HRS Prime Healthcare 2013 DSH SSI Fraction Dual Eligible Days Group
15-2402GC	HRS DCH 2012 DSH SSI Fraction Dual Eligible Days Group
15-2403GC	HRS DCH 2012 DSH Medicaid Fraction Dual Eligible Days Group
15-2629GC	HRS UHHS 2012 DSH Medicaid Fraction Dual Eligible Days Group
15-2630GC	HRS UHHS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2681GC	HRS Prime Healthcare 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1317GC	HRS UHHS 2013 DSH SSI Fraction Dual Eligible Days Group[88]
16-1318GC	HRS UHHS 2013 DSH Medicaid Fraction Dual Eligible Days Group[89]
16-2439GC	HRS LSU 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-2442GC	HRS LSU 2013 DSH SSI Fraction Dual Eligible Days Group
17-0438GC	HRS WKSH 2013 DSH SSI Fraction Dual Eligible Days Group
17-0439GC	HRS WKSH 2013 DSH Medicaid Fraction Dual Eligible Days Group
19-2147G	HRS CY 2014 DSH SSI Fraction Dual Eligible Days Group
19-2149G	HRS CY 2014 2013 DSH Medicaid Fraction Dual Eligible Days Group
20-0056GC	HRS Willis-Knighton CY 2016 DSH SSI/Medicaid Dual Eligible Days Group

[88] By letter dated April 4, 2022, the Board expanded Case Nos. 15-2629GC and 15-2630GC to include CY 2012 and consolidated them with Case Nos. 16-1317GC and 16-1318GC respectively. As a result of this consolidation, the Board closed Case Nos. 16-1317GC and 16-1318GC.

[89] *See supra* note 88.

APPENDIX D

June 10, 2022 Board Letter to QRS
Deferring Show Cause Order and Closure of Cases
Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)
Due to QRS Filing in California Central District Court

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Scott Berends, Esq.
Federal Specialized Services
1701 S. Racing Avenue
Chicago, IL 60608-4058

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

RE: ***Deferring Show Cause Order & Closure of Cases***
Case No. 09-1903GC, *et al.* (*see* attached list of 80 group cases[1])

Dear Mr. Berends and Ravindran:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS"), the Providers' designated representative, filed a consolidated request for expedited judicial review ("EJR") on January 12, 2022 for the above-referenced 80 group cases involving, in the aggregate, over 950 participants.[2] On January 20, 2022, the Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review these 80 cases for jurisdictional issues due to the sheer size of these groups, the number of Medicare contractors involved and pending unresolved jurisdictional challenges filed in at least 8 of the group cases.[3] Shortly thereafter, on January 24, 2022, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") to manage the jurisdictional review process for these 80 group cases and 950+ participants, assigning ongoing tasks to both parties and making known the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2). *Following the Board's Scheduling Order, the Providers were* ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order*. On February 14, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a lawsuit in the U.S.

[1] The Board has excluded Case No. 20-0162GC entitled "Hartford Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group" from the instant Scheduling Order because it was adjudicated by the Board and closed on March 17, 2022, several weeks prior to QRS' April 8, 2022 letter. Further, the Board added the optional group under Case No. 19-2515G entitled "QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group" which was included in the EJR Request filed on February 16, 2022 that is identical to the one filed on January 20, 2022. *See* Board letter (Jan. 24, 2022) at n.26, n.27 for a more detailed explanation.

[2] *See supra* note 1.

[3] FSS' Response to Providers' Request for EJR (Jan. 20, 2022) identified the jurisdictional challenges as being pending and unresolved in the following 8 group cases:

- Case No. 18-1738GC (JC filed 10/14/21) because the providers improperly expanded the appeal request;
- Case No. 19-0014GC (JC filed 3/8/21) because several providers failed to include the group issue in their hearing request, failed to timely add the issue to their individual appeals and failed to properly transfer into the group and because the group providers improperly expanded their appeal request.
- Case No. 19-0164GC (filed 11/10/21) because: (1) the providers transferred the same issue to another group (Case No. 18-0037GC); and (2) the DSH – Medicaid Fraction/Dual Eligible Days issue was improperly/untimely added.
- Additional jurisdictional challenges have been filed in Case Nos. 14-1171G (filed 8/6/15), 14-1818G (filed 9/14/15), 14-3306G (filed 12/28/15), 14-3308G (filed 12/28/15) and 20-0244G (filed 6/24/21).

District Court for the Central District of California ("California Central District Court") seeking judicial review on the merits of its consolidated EJR request in these 80 cases. On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed the requisite responses. On April 8, 2022, ***roughly 2½ months after the Board's January 24, 2022 Scheduling Order***, QRS broke its silence and informed the Board and the Medicare Contractors of this lawsuit by filing the "Providers *Response* to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903, et at [*sic*]"[4] ("Providers' Response"). In its entirety, Providers' Response stated:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

On April 18, 2022, FSS filed a request for dismissal of the Providers' cases for failure to comply with the Board's Scheduling Orders ("Request for Dismissal"). On April 24, 2022, the Board issued to the Providers an Order to Show Cause Why Dismissal Is Not Warranted ("Order to Show Cause") and the parties filed responses thereto.

As set forth in more detail below, the Board hereby takes the following actions:

1. Closes these 80 cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Defers action on its Order to Show Cause, based on QRS' numerous, egregious, regulatory violations, until such time as there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[5]

Procedural Background

On January 12, 2022, QRS filed an EJR for the above 80 group cases.[6] *In the majority of these group cases*, QRS filed an electronic copy of the Schedule of Providers ("SoP"), with supporting

[4] (Emphasis added.)
[5] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,
[6] *See supra* note 1.

documentation, one or two days prior to the EJR request.[7] Per Board Rule 20.1.1 (Nov. 1, 2021), the SoP must "demonstrate[] that the Board has jurisdiction over ***each*** participant named in the group appeal."[8] Significantly, the overwhelming majority of these cases are *optional* groups and roughly 90 percent of the over 950 participants are in those *optional* groups. As explained at Board Rule 12.3.2 (Nov. 1, 2021), "[p]roviders not under common ownership or control may choose to join together to file an ***optional*** group appeal for a specific matter that is common to the providers for any fiscal year that ends in the same calendar year, but they are not required to do so."[9] In contrast, Board Rule 12.3.1 explains when a mandatory common issue related party ("CIRP") group appeal is required, "[p]roviders under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. See 42 C.F.R. § 405.1837(b)."[10]

On January 20, 2022, FSS requested a 60-day extension of time to review these 80 cases for jurisdictional issues "due to the sheer size of the groups, the recent closure of several of the groups and the number of [Medicare Contractors] involved."[11] FSS also noted that there were pending jurisdictional challenges in 8 of the 80 cases.[12] Finally, FSS noted that jurisdiction is paramount and maintained that its request was consistent with the intent of Board Rules 44.6 and 22 which give Medicare Contractors 60 days to review the final SoP (including the underlying jurisdictional documentation for each participant) and file jurisdictional challenges, as relevant, following receipt of the final SoP.

The January 24, 2022, Scheduling Order explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[13] The Scheduling Order further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework status.[14] While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decisions. Accordingly, the Scheduling Order notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals as follows:

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[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are 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."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. Accordingly, the Board: (1) will follow the standards set forth in the CMS regulations at 42 C.F.R. § 405.1801(d)(2) when calculating the Board's 30-day time period by excluding all days where the Board is not able to conduct its business in the usual manner; and (2) has stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.[15]

In addition, the Scheduling Order set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant, documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Further, the Board requested that the record in these cases be supplemented with certain germane information from the individual appeals, from which participants had been transferred, to ensure the record before the Board was complete for purposes of the Board's jurisdictional review.[16] Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that "A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]" [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request)."[17]

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[15] (Footnote omitted and bold and underline emphasis added.)

[16] Specifically, the Board stated: "The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case* ***so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases***." Board letter (Jan. 24, 2022) (emphasis added).

[17] (Emphasis in original.)

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' request for an extension prior to the Rule 44.3 30-day time deadline. Nor did QRS file any objection to the Scheduling Order. QRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed jurisdictional challenges in 15 distinct group cases. These challenges were different from, and in addition to, the 8 pending, unresolved, jurisdictional challenges that FSS noted in its initial January 20, 2022 response.[18]

On April 8, 2022, roughly 2½ months after the Board issued its Scheduling Order, QRS broke its silence to file the 4-sentence Providers Response[19] which, in whole, reads:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

Providers' Response makes clear that the Providers are abandoning the Board's jurisdictional review process and are not complying with the Board's January 24, 2022 Scheduling Order by stating: "*the Providers consider that proceedings before the PRRB have been* ***exhausted*** [and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[20]

On April 18, 2022, FSS filed its Request for Dismissal wherein it requested the Board either: (1) dismiss these 80 cases for "failure to comply with Board rules and deadlines [in the January 24, 2022 Scheduling Order] and for, in essence, abandoning the issues before the Board" by filing a complaint in federal district court; or (2) "[i]n the alternative, . . . dismiss each of the cases for which the MACs have filed jurisdictional or substantive claim challenges."

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[18] *See supra* note 3.

[19] Again, the Board notes that the caption for April 8, 2022 filing clearly notes it was intended as a response to the Board's Notice of Stay and Scheduling Order: "Providers Response to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903GC, et at (See Attached list)"

[20] Board Scheduling Order n.23 (Apr 21, 2022) (emphasis added).

In response to these filings, the Board issued an Order to Show Cause, on April 21, 2022, directing QRS to respond, no later than May 5, 2022, to FSS' Request for Dismissal and to Show Cause why the Board should not dismiss these 80 cases in their entirety based on:

- The Providers' failure to timely respond to the Medicare Contractor's Extension Request or the ensuing January 24, 2022 Board Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- The Providers' abandonment of the Board's ongoing jurisdictional review process and refusal to comply with the Board's Scheduling Order for the management of that review process.

On May 5, 2022, QRS filed a response on behalf of the Providers urging the Board to not dismiss the cases because, "although it is the desire of the Providers to cooperate with the Board and the MAC, the Providers explain the basis for their commencement of an action in federal court, which the Providers continue to believe is legally appropriate, and why the Board should not dismiss these cases." QRS explains that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that they "notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court." QRS contends that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that *the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases*." In taking this position, the Providers readily recognize that they "are aware that there are other extenuating circumstances, such as COVID related staffing issues, which are hampering the Board's ability to process EJR requests."[21] However, "[w]hile sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met." Finally, QRS asserts that "although the Providers have commenced an action in federal court, since the Board appears to believe that it retains authority over these cases, the Providers respond to the jurisdictional issues that Federal Specialized Services ("FSS") has raised."

Given the nature of QRS' response, and the arguments presented therein, the Board issued a Scheduling Order on May 6, 2022, directing that any response by FSS to QRS's filing must be filed no later than May 12, 2022. Accordingly, FSS responded on May 9, 2022 contending that:

1. The Providers' contention in its May 5, 2022 filing that the Board lacked the authority to allow the Medicare Contractors additional time to review and raise jurisdictional challenges was not timely and properly raised.

2. The Providers improperly waited nearly 2 months to advise the Board that such a complaint had been filed. The Providers' contention that CMS was responsible for advising the Board of a complaint's filing is countered by the fact that "there is no record that the summons was

[21] QRS letter dated May 5, 2022 filed in Case No. 09-1903GC, *et al*.

served" and that service did not occur until two months later on April 12, 2022 when an alias summons was issued in the case. Further, "when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed.

3. The Providers failed to timely respond to any of the jurisdictional challenges raised by the Medicare Contractors.

4. After a lawsuit is filed, 42 C.F.R. § 405.1842(h)(3)(iii) does not prohibit further Board action to determine jurisdiction.[22]

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced 80 cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right 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, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

[22] 42 C.F.R. § 405.1842(h)(3)(iii) states, "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved."
[23] (Emphasis added).

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.

> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[24]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[25] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[26]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this

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[24] (Emphasis added).
[25] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).
[26] (Emphasis added.)

and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[27] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[28] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[29]

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[27] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[28] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[29] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[30] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 80 group cases, with over 950 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[31] process is important to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Indeed, these concerns are very real and evident in these 80 group cases.

In compliance with the Board's January 24, 2022 Scheduling Order, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. On March 14, 2022, FSS timely filed a comprehensive response noting that Jurisdictional Challenges and/or Substantive Claim Challenges had been filed in 15 of the 80 group cases encompassed in the instant EJR request. These challenges as well as separate challenges or jurisdictional issued raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case Nos. 13-3191GC, 13-1440G, 13-2678G, 13-2693G; 14-1174G; 15-1067G; 15-2385G, 20-0250G, 20-0244G.

- Jurisdictional challenges identifying certain participants may not have been validly transferred from an individual appeal into the relevant group because the issue that the participant sought to transfer was not properly part of the individual appeal (*i.e.*, was

[30] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.
[31] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

neither properly part of the appeal request nor properly added pursuant to 42 C.F.R. §§ 405.1835(a)-(b), (e)). In some situations, the Medicare Contractor has suggested that the transferred issue is narrower than the group issue and, as such, that there has been an improper attempt to expand the issue from the individual appeal. Cases affected include Case No. 13-3191GC, 13-2678G, 15-2385G, 18-1738G, 19-0014GC, 19-0164GC.

- Jurisdictional challenges arguing that certain providers should be dismissed because they were already a participant for the same issue and year in another appeal. Cases affected include Case Nos. 15-0018G, 15-3031G, 15-3039G and 19-0164GC.

- Jurisdictional challenge claiming that certain providers should be dismissed because they appealed prematurely under 42 C.F.R. § 405.1835(c) for failure to timely issue a determination. Cases affected include 15-0018G and 15-1419G.

- A jurisdictional challenge that Case No. 15-1067G is not valid because the group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for this group.

- A jurisdictional challenge in Case No. 15-2385G alleging that there is no documentation establishing that a provider was properly transferred into the group.

- Jurisdictional challenges identifying multiple providers that were ***improperly*** listed in the SoP after they were ***previously*** withdrawn by QRS, dismissed by the Board or its transfer to the group was denied. Cases affected include Case Nos. 13-2678G, 13-2693G, 13-1440G, 14-1174G, 15-1419G, 15-3031GC, and 15-3039G.[32]

- Jurisdictional challenges claiming that, because certain providers are commonly owned or controlled, they could be required to be part of a mandatory CIRP group. Accordingly, they may not be a participant in the relevant optional group and could be subject to dismissal. Cases affected include Case Nos. 15-1419G, 15-3031G, 18-1259G, 18-1260G.[33]

- Jurisdictional challenges raising questions whether QRS was an authorized representative of certain participants. Cases affected include Case Nos. 13-2678G, 13-2693G, 15-2385G.

- Jurisdictional challenges in Case No. 16-1142G, 18-1259G, and 18-1260G averring that the determination at issue for a participant was not included as required by 42 C.F.R. § 405.1835(b) and should be reviewed for dismissal.

[32] Most of the challenges for the withdrawn/dismissed participants are raised through exhibits attached to the jurisdictional challenges showing correspondence either from QRS withdrawing the participant or from the Board dismissing the participant and/or denying transfer to the relevant group.

[33] In one situation, the Medicare Contractor has identified a CIRP group for the same issue and year in which it believes the provider is a participant and, if so, that duplication would be a clear violation of the mandatory CIRP regulation and Board Rule 4.6 prohibiting duplicate appeals. In another, the Medicare Contractor identified 2 CIRP providers participating in the same *optional* group with an aggregate amount in controversy in excess of $50,000, which if true would violate the mandatory CIRP regulation.

- Jurisdictional issues noted in Cases No. 20-0248, 20-0250G, and 20-0411GC regarding certain providers that failed to properly establish an individual appeal prior to transferring to the group because they failed to *timely* file their individual appeal within the period allowed by 42 C.F.R. § 405.1835(a)(3).

- Jurisdictional challenges filed in Case Nos. 14-1818G, 14-3306G, 14-3308G allege that certain providers did not include a claim for the item on their cost report and did not identify the item as a self-disallowed cost by identifying the issue as a protested amount on their cost report.

- A substantive claim challenge[34] was filed for Case No. 19-2513 claiming that none of the providers included an appropriate claim for the appealed item in dispute as required under 42 C.F.R. § 413.24(j).

In addition, the Board through its ongoing review of jurisdiction, and other procedural issues, in these 80 group cases, has identified ***numerous, material,*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board include, but are not limited to, the following.

1. *Prohibited Duplicate Appeals*

   There are violations of Board Rule 4.6 prohibiting duplicate appeals. For example, the participants in Case No. 09-1903GC (BHCS 07 DSH Dual Eligible Days) are duplicative of the participants, and the cost reporting periods, at issue in Case Nos. 13-3896GC and 13-3938GC.

2. *Providers With No Appeal Rights*

   There are additional providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue. Other examples outside of those identified by the Medicare Contractors include Case Nos. 20-0248G and 20-0250G.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants in Excess of $1 million*

   There are a significant number of participants in these 80 groups for whom QRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though they were either ***previously withdrawn by QRS*** from the relevant group case, the Board denied the transfer to the group appeal ***or*** the Board dismissed them. Although the Board has not completed its review, the following examples from only 8 of the 80 cases alone demonstrate that QRS is ***improperly*** pursuing reimbursement ***in excess of $1 million.***

[34] *See supra* note 31 (discussing what the Board's use of the term "substantive claim challenge" means).

Such action on the part of QRS raises significant fraud and abuse concerns,[35] and the Board takes administrative notice that this is not an isolated concern. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[36] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings.* Recent examples of group cases in which the Board has identified that QRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** prior group cases in which withdrawals were ***required*** under settlement with the government but were not withdrawn, even after notification was sent to QRS separately by the relevant Medicare contractor or FSS

[35] Based on its preliminary review of just some of these cases, the Board fully expects to identify a significant number of other situations where QRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of the SoPs that QRS refiled and is relying on for its consolidated EJR request (*e.g.*, relying on 9+ year old SoPs in Case Nos. 13-3942G and 13-3944G where there are 106 participants in the aggregate). Indeed, the Medicare Contractors have already identified some of these other situations. *See supra* note 32 and accompanying text. Further, in its May 5, 2022 response to the Board's Show Cause Order, QRS sets forth in Exhibit 4 a listing of the 14 previously withdrawn/dismissed providers that the Medicare Contractors had identified *with an AIC in the aggregate of $1,054,115.* Seven of these 14 (with an aggregate AiC of $476,115) overlap with the Board's preliminary listing, *infra*, of previously withdrawn/dismissed providers:

- Case No. 13-2678G – #22 Leesburg RMC and #27 Union General Hospital; and
- Case No. 13-2693G – #26 Wuesthoff MC;
- Case No. 14-1174GC – #19 Shands Jacksonville Medical Center, #23 Leesburg Regional Medical Center, #28 Union General Hospital, and #39 MedCenter One Inc.

The ones not on the Board's list have an aggregate AiC of $578,000 and include:

- Case No. 13-2678G – #38 St. Alexius MC and #39 Bismarck MedCenter One;
- Case No. 15-0018GC – #4 Cox Medical Center;
- Case No. 15-1419G – #1 Lawrence & Memorial Hospital on SoP-A and #21 FF Thompson Hospital on SoP-B;
- Case No. 15-3031G – #26 Wilkes Regional MC; and
- Case No. 15-3039G – #25 Wilkes Regional MC.

Accordingly, the AiC of Board's preliminary listing of previously withdrawn/dismissed participants would increase from $1,038,115 to ***$1,616,115*** if these additional 7 are included. The Board is confident that it would identify additional instances if it were to complete its jurisdictional review process (*e.g.*, the Medicare Contractors identified Case Nos 13-1440G (C-4) and 14-1171G as having previously withdrawn/dismissed providers but those cases are ***not*** on QRS' list of 14). The Board listing, plus the Medicare Contractors listing, demonstrates the hollowness of QRS' offer to simply withdraw the 14 Providers the Medicare Contractors identified (roughly 30% of what has thus far been identified this issue). This is more than a mere oversight, as QRS clearly failed to exercise any, much less due, diligence, when it resubmitted stale SoPs concurrent with the consolidated EJR request.

[36] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).

include: Case Nos. 10-0924GC,[37] 12-0281G,[38] 13-3075,[39] 13-3928G, 13-3941G,[40] 14-4385GC, 14-4386GC,[41] 14-4171GC, 14-4172GC,[42] 15-0020G, 15-1423G,[43] 15-0585GC, 15-0587GC,[44] 15-3484GC,[45] 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, 16-1349GC,[46] 17-0568GC, and 19-2376GC. [47] These examples highlight, *at a minimum*, QRS' reckless disregard for its

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[37] As part of an EJR determination dated August 2, 2019, the Board notified QRS that it had *improperly* included Participant #1 on the SoP because it had filed a void transfer request to transfer from a case which the Board had closed more than 3 years earlier -- Case No. 08-1716.

[38] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly"* included Participant #9 on the SoP because the Board previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeal.

[39] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly"* included a Provider on the SoP for Case No. 13-3075GC because, on October 24, 201**3**, the Board had previously denied the request to transfer because the Provider did not timely appeal the issue for which transfer was requested.

[40] As part of an EJR determination dated April 8, 2019, the Board notified QRS that it had "*improperly"* included Rapid City Regional Hospital as a participant in the SoPs for Case Nos 13-3928G and 13-3941G because the Board previously had issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[41] As part of an EJR determination dated June 24, 2019, the Board notified QRS that the SoP for Case Nos. 14-4385GC and 14-4386GC had failed to comply with Board rule by "*improperly*" including Scottsdale Osborn Medical Center because the Board had previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[42] As part of an EJR determination dated September 30, 2021, the Board admonished QRS for "*improperly*" including Mercy Hospital Springfield on the SoP for Case No. 14-4171GC and 14-4172GC because the Board had issued a jurisdiction determination on March 25, 201**5** dismissing the dual eligible days issue as untimely added to Case No. 14-0460 and denying transfer from Case No. 14-0460 to the respective group appeals. The Board reminded QRS that it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings.

[43] As part of an EJR determination dated April 11, 2019, the Board notified QRS that it had "*improperly*" included Lawrence & Memorial Hospital on the SoP for Case No. 15-0020G and 15-1423G because the Board previously issued a determination dated November 7, 2016 (as modified by letter dated December 12, 201**6**) denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[44] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly*" included 3 different providers on both the SoP Case Nos. 14-0585GC and 15-0587GC because, by letters dated May 14, 2015, July 9, 2015, November 17, 2015, the Board had denied transfers of those 3 providers to both Case Nos. 14-0585GC and 15-0587GC.

[45] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly*" included a provider on the SoP even though the Board had denied jurisdiction in the individual appeal and denied transfer therefrom on February 23, 201**6** and, *following a request for reconsideration*, ***upheld*** that denial by letter dated June 17, 201**6**.

[46] QRS failed to withdraw a provider from Case Nos. 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, and 16-1349GC even though: (1) the Bankruptcy Settlement Agreement entered into between the Provider and the CMS in June 2021 required within 30 days of the Bankruptcy Settlement Agreement's effectuation to "withdraw their participation in PRRB Appeals . . . or appeals pending in any venue or jurisdiction"; (2) On September 1, 2021 ,the Medicare Contractor notified QRS by email of its obligation to withdraw per the agreement; and (3) on September 17, 2021, the Medicare Contractor filed a Request for Dismissal of that provider from these cases based on QRS' in action. Notwithstanding, QRS took no action and, in particular, did not respond within the 30 days allotted under Board Rule 44.3 and, accordingly, the Board dismissed the provider and reprimanded QRS for its failure to comply with the Bankruptcy Settlement Agreement.

[47] In a Board determination dated August 12, 2020 on a Medicare Contractor challenge to certain issue transfers, the Board reopened Case No. 17-0568 to dismiss 2 providers that had *improperly* transferred from 10+ month ***closed*** cases, and reopened and rescinded the EJR determination for Case No. 17-0568GC in order to effectuate the void/invalid

basic responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 1,500 open cases (of which there are more than 1,000 CIRP groups and 130 optional groups), QRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[48] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[49]

Especially egregious examples of QRS's failure to competently fulfil its responsibilities as a Provider Representative *in 8 of the instant 80 group cases* include:

a. Case No. 13-1419G – On January10, 2022, 2 days prior to filing its EJR request, QRS refiled what it identified as its original SoP dated June 4, 2014.[50] However, nearly 6 years after filing the original SoP, and nearly 2 years before refiling it as part of its EJR request, QRS *filed* ***in OH CDMS***[51] its withdrawal of Participant #11, St. Francis North Hospital (Prov. No. 19-0197, FYE 6/30/2006, amount in controversy ("AiC") $330,000) on February 25, 2020. Under Board Rules, withdrawals are self-effectuating.[52] Despite its withdrawal, QRS has continued to improperly include St. Francis North Hospital on the Final Schedule of Providers and pursue reimbursement.

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transfers and dismissals. Further, the Board dismissed those same two providers from Case No. 19-2376GC as it had bifurcated from 17-0568GC and their participation in Case No. 19-2376GC depended on the validity of was dependent on that bifurcation. Finally, the Board admonished QRS, as the Group Representative (as well as the Representative in the individual cases) for submitting transfer requests from these individual appeals to Case No. 17-0568GC that they should have known were both invalid and void since the individual cases had been closed for over ten months when the transfer requests were made. The Board reminded them that as representatives they have the responsibility to track and manage their cases and ensure they exercise due diligence prior to making filings.

[48] The Board has identified one SoP where QRS noted withdrawals. The SoP for Case No. 15-0018G that is attached to the January 12, 2022 consolidated EJR request shows an example of an SoP where QRS *correctly* noted 2 separate providers that were previously withdrawn – Participant #3, Prov. No. 19-0125, on SoP-A and Participant #20, Prov. No. 33-0074, on SoP-B. Similarly, the cover letter to the SoP filed in Case No. 14-2217GC includes the withdrawal of 2 participants, Prov. Nos. 340158 and 34-0183, and neither of these withdrawn participants were included on the attached SoP.

[49] For example, QRS filed an *amicus curiae* brief in support of the hospitals position in the case, *Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party "explain in detail" its reason for non-compliance." (Emphasis added.)

[50] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[51] The Board's electronic filing system is known as the Office of Hearings Case and Document Management System ("OH CDMS") and was launched on a voluntary basis in August 2018. The Board implemented mandatory electronic filing on November 1, 2021. The OH CDMS records readily available to the parties for Case No. 13-1419G show that Philip Payne of QRS filed the request for withdrawal on February 25, 2020 at 3:04 pm.

[52] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice

b. Case No. 13-1440G – On January 10, 2022, 2 days prior to filing its EJR request, QRS refiled what is identified as its original SoP dated June 4, 2014.[53] However, by letter dated October 16, 2017, the Board issued its decision to QRS denying the transfer of Participant #14, Cape Fear Valley Medical Center (Prov. No. 34-0028, FYE 9/30/2006, AiC $38,000) from Case No. 13-3632 to Case No. 13-1440G. Notwithstanding the denial, QRS has continued to improperly pursue reimbursement for that provider on the Final SoP submitted with the instant EJR Request and failed to include the Board's dismissal in the documentation attached to that Schedule of Providers.

c. Case No. 13-2678G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoP dated October 27, 2014.[54] However, QRS failed to update the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2014 filing. Furthermore, QRS continues to pursue reimbursement on behalf of these Providers *after* they had been removed from Case No. 13-2678G.

   i. On April 29, 2015, QRS withdrew Participant #22, Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007, AiC $55,115).

   ii. On May 17, 2016, QRS withdrew Participant #18 Shands Jacksonville Medical Center (Prov. No. 10-0001, FYE 6/30/2007, AiC $24,000) following a Board request dated May 7, 2016 for QRS to provide a copy of the missing letter of authorization from the Provider.

   iii. On April 15, 2015, the Board notified QRS that, in connection with Participant #27 Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007, AiC $22,000) the Board was dismissing the DSH Dual Eligible Days (Medicaid and SSI Fraction), and other issues in Case No 13-1904 and denying transfer of that issue to 13-2678G.

d. Case No. 13-2693G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled roughly 4/5 of its original SoP, dated October 27, 2014,[55] and the

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acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

[53] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached the SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[54] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the roughly 1950 pages of attachments.

[55] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2130+ pages of attachments.

remaining 1/5 of that document on January 19, 2022, one week after filing its EJR request.[56] However, in December 2017, the Board notified QRS of its decision to deny transfer of Wuesthoff Memorial Hospital (Prov. No. 10-0092, FYE 9/30/2008) from Case No. 13-2106 to Case No. 13-2693G because the revised NPR at issue did not adjust the issue for which transfer was requested. Notwithstanding, QRS has continued to improperly pursue reimbursement for the Provider as Participant #26 on the SoP with an AiC of $115,000.

e. Case Nos. 13-3942G and 13-3944G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case Nos. 13-3942G and 13-3944G which are each ***dated December 2, 2012***.[57] However, on May 24, 2017, the Board notified QRS of its decision to deny the transfer of Rapid City Regional Hospital (Prov. No. 43-0077, FYE 6/30/2009) from Case No. 14-1297 to Case Nos. 13-3942G and 13-3944G because the Provider did not timely file its individual appeal request. Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #47 on the SoP for Case No. 13-3942G with an AiC of $21,000 and as Participant #44 on the SoP for Case No. 13-3944G with an AiC of $105,000.

f. Case No. 14-1816G—On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case No. 14-1816G which is dated April 7, 2015.[58] However, on November 18, 2015, the Board notified QRS of its decision to deny the transfer of Larkin Community Hospital from Case No. 14-3904 because the Provider's original individual appeal request did not include the SSI fraction dual eligible days issue (nor was it timely added to the case). Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #8 on the SoP with an AiC of $44,000.

g. Case No. 14-1174G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled its original SoP, dated March 20, 2015.[59] However, QRS failed to update

[56] As the SoP with supporting documentation and cover letter consists of 2137 pages, QRS divided the filing into 5 parts and uploaded parts 1, 2, 4 and 5 on January 11, 2022 and the missing part 3 on January 19, 2022, a week after it had filed the consolidated EJR request on January 12, 2022.

[57] While the cover letters transmitting the SoPs with supporting jurisdictional documentation for Case Nos. 13-3942G and 13-3944G are dated December 30, 2014 and December 26, 2014 respectively, each of the attached SoPs list the "date prepared" as December 2, 2012. Further, the caption for the filing in OH CDMS identifies these filings as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the aggregate roughly 3900 pages of attachments to these SoPs (1980+ pages for Case No. 13-3942G and 1900+ pages for Case No. 13-3944G).

[58] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated April 28, 2015 and the attached SoP lists the "date prepared" as April 7, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 863 pages of attachments.

[59] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated March 31, 2015 and the attached SoP lists the "date prepared" as March 20, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2250 pages of attachments.

the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2015 filing and, as such, is improperly pursing reimbursement on behalf of these providers.

i. By letter dated April 7, 2015, the Board notified QRS that the Board was dismissing Case No. 13-2753 for Bismarck MedCenter One (Prov. No. 35-0015, FYE 12/31/2007) in its entirety and denied transfer of the DSH SSI Fraction/Dual Eligible days issue to Case No. 14-1174G. QRS has continued to improperly pursue reimbursement for the Provider as Participant #39 on the SoP with an AiC of $50,000.

ii. By letter dated April 15, 2015, the Board notified QRS that the Board was dismissing all issues except the rural floor budget neutrality adjustment ("RFBNA") issue in Case No. 13-1904 for Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007) because QRS *only* obtained authorization to act on behalf of the Provider for the RFBNA issue. Accordingly, the Board denied the transfer of the Dual Eligible Days (Medicaid & SSI fractions) issue from Case No. 13-1904 to Case No. 14-1174G. However, QRS has continued to improperly pursue reimbursement for the Provider as Participant #28 on the SoP with an AiC of $10,000.

iii. On April 29, 2015, QRS filed its request to withdraw Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite its withdrawal, QRS continues to improperly pursue reimbursement for the Provider as Participant #23 on the SoP with an AiC of $138,000.

iv. On May 17, 2016, QRS filed its request to withdraw Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite this withdrawal, QRS has continued to improperly pursue reimbursement for the Provider as Participant #19 on the SoP with an AiC of $86,000.

4. Prohibited Participation of CIRP Providers in Optional Groups

There are additional violations, or potential violations, of the mandatory CIRP group requirements at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R § 405.1837(b)(1). For example, on March 17, 2022 (several weeks prior to QRS' April 8, 2022 letter), the Board issued a request for additional information in two *optional* group cases (Case Nos. 19-2513G and 19-2515G), identifying potential CIRP compliance issues and QRS submitted a partial response.[60] The Board has a similar open inquiry from January 2021 on the participation of Deaconess Medical Center in Case No. 17-1412G notwithstanding the fact that the provider is part of Empire Health and Empire Health has an open CIRP group for the same issue and year under Case No. 17-0554GC. Upon further review, the Board would issue similar

[60] The mandatory CIRP regulation applies to commonly owned ***or*** *controlled* providers. QRS' response failed to address one provider and, for 2 providers, the response did not adequately address whether there was "control" (*e.g.*, control of the provider through a management agreement).

development letters for CIRP issues identified in other groups, including Case Nos. 13-1419G, 13-3942G, 13-3944G 15-0018G, 15-1419G, 15-3039G, and 16-1750.

5. *Unauthorized Representation of Participants*

   The Board has identified multiple situations where QRS failed to obtain proper authorization from the provider to be a participant in the relevant group. In these situations, the Board has dismissed the provider from the group. For example, in Case No. 13-1419G, QRS failed to provide documentation of proper authorization from Participant #2, Pacifica Hospital of the Valley ($13,000 AiC). Board Rule 5.4 (Mar. 2013) specifies that "[t]he letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider" and "must reflect the Provider's fiscal year under appeal." Contrary to Board Rule 5.4, the authorization letter is not on hospital letterhead and does not identify the organization to which the signatory belongs.

6. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— The majority of the 950+ participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[61] The Medicare Contractors, as discussed *infra*, have already identified issues with some transfers and the Board expects it would identify additional issues if it were to complete its jurisdictional review.

7. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues where one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation. Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, in its April 8, 2022 filing, that it had abandoned the Board's jurisdictional review process as discussed above. QRS reinforced its intent in the Providers' response to the Board's Order to Show Cause, as shown by the following excerpts:

[61] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.

- "The Board, however, failed to render its decision within the thirty-day period. Instead, partly at the request of FSS, the Board informed the Providers that the Board required an additional sixty days to review jurisdictional documents.[1]"

- Footnote 1, appended to the above quote, reads: "*The Providers are aware that there are other* ***extenuating circumstances***, such as COVID related staffing issues which are hampering the Board's ability to process EJR requests. While certainly sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met. The Providers' filing of their EJR complaint, therefore, should not be viewed as casting aspersions on the pace with which the Board is addressing these issues in any way. It simply reflects the objective fact that a decision was not issued within thirty days."[62]

While QRS' April 8, notice did not provide the case number assigned to the Complaint the Providers filed in federal court, PACER (the federal courts' filing system) verifies that the Providers' Complaint, relevant to this decision, was filed in federal district court on February 14, 2022. However, QRS waited nearly two months (54 days) to notify the Board, FSS and the Medicare contractors of the Complaint and its position that the Board proceedings were otherwise

[62] Provider's Response to FSS' Request for Dismissal at n.1 (May 5, 2022). In this situation, it is unrealistic and naive for QRS to expect the Board to complete the prerequisite jurisdictional review process, as well as a review of the EJR request, itself within 30 days. The unreasonableness of QRS' position is highlighted by the following facts:

- The consolidated request consists of 80 cases involving over 950 participants;
- The SoPs with supporting documentation involve tens of thousands of documents. For example, the 8 cases identified as improperly listing previously dismissed/withdrawn participants (Case Nos. 13-1419G, 13-1440G, 13-2678G, 13-2693G, 13-3942G, 13-3944G, 14-1174G, and 14-1816G) involve, in the aggregate, nearly 12,500 pages of attachments which averages to roughly 40 pages per participant (12,473 pages/315 participants). Projecting that to the 950+, the Board estimates that the SoPs for these 80 cases involve over 37,000 pages of documentation related to jurisdiction.
- The majority of the cases at issue are legacy cases and were not filed initially in OH CDMS. As a result, the jurisdictional documentation was filed in hard copy.
- The Agency, including the Board has been in maximum telework status since March 2020 with limited and, at times, no access to hard copy files and filings. Indeed, during the 30 days immediately following the filing of the January 12, 2022 consolidated EJR request, the Baltimore/DC metro area was experiencing the effects of the surge in COVID-19 cases due to the Omicron variant and the Agency remained in maximum telework status and no staff members were in the Board's offices until mid-February 2022 when certain skeletal staff members began coming into the Board's offices. The Agency only lifted that status on May 23, 2022.
- Review and navigation of scanned PDF copies of SoPs is exponentially more time consuming that review of a hard copy SoP that is tabbed and documents can be accessed both horizontally and vertically. As set forth in Board Rule 21, the SoP is organized by participant (Tab 1 is participant 1, Tab 2 is participant 2, etc.) and each participant's jurisdictional documents are organized by Tabs A through H. An example of horizontal access is reviewing the jurisdictional documentation provider by provider. An example of horizontal access is solely looking at the representation letter housed behind Tab H of each provider and this type of access is important for purposes of consistency and quality control. As the PDF documents upload here do not have bookmarks, vertical navigation is not an immediate resource. Some of the optional groups are very large making navigation of an SoP, such as flipping between providers, very challenging. For example, Case No. 13-2693G involves 54 participants and the SoP is spread across 5 pdf documents containing 2137 pages, in the aggregate (and, again, contains no bookmarks to facilitate navigation).

"exhausted"/done.[63] This delay caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 950+ participants in the 80 group cases.[64] More concerning is QRS' attempt to undermine, and bypass, the Board's regulatory and statutory duty to conduct a complete and thorough jurisdictional review process for all of the participants in these cases. QRS essentially self-declared that all 950+ participants in these groups have a right to pursue EJR in federal district court (regardless of whether the Board has jurisdiction over such providers, including instances of previously dismissed or withdrawn providers). If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.[65]

Accordingly, based on QRS' failure to comply with the Board's filing deadline set forth in its Scheduling Order, the Board exercised its authority under 42 C.F.R. § 405.1869(b)(2) and required QRS to show cause why the Board should not dismiss the appeals in the attached listing based on:

- QRS' failure to timely respond to the Medicare Contractor's Extension Request or the Board's ensuing Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- QRS' abandonment of the Board's ongoing jurisdictional review process, and refusal to comply with the Board's Scheduling Order for the management of that review process.

B. Board Deferment of its Order to Show Cause Why Dismissal is Not Appropriate

42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

[63] While the notice identified the jurisdiction in which the lawsuit was filed, it did not include either a copy of the complaint, the date the lawsuit was filed, or the case number established for the lawsuit.
[64] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and is processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 80 cases covered in this notice*, the Board had 253 cases with EJR requests pending of which 130 were filed by QRS. On or after April 8, 2022, EJR requests were filed for an additional 207 cases of which 154 were filed by QRS. As these cases were primarily group cases, they involved thousands of participants in the aggregate.
[65] As explained *supra*, a partial review of just 8, of the 80, group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $1 million in controversy on the related SoPs.

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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[66]

The Board initially suggested, in its letter dated April 21, 2022, that the clause "proceedings on the legal question or matter at issue" in § 405.1842(h)(3)(iii) only addressed proceedings "on the substance of the EJR request and does not address pre-requisite jurisdiction or other procedural issues that may arise in an appeal or proceedings before the Board." However, upon further reflection, the Board agrees that this regulation ***bars any further Board proceedings*** in these 80 group cases, including proceedings on pre-requisite jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring consideration of its Order to Show Cause until, or if, the Administrator remands these cases back to the Board.

In response to the Board's April 21, 2022 Order to Show Cause, QRS asserted that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and *reasonably believed that further proceedings before the Board prohibited by regulation*."[67] QRS then stated that it "notified the Board by letter dated April 8, 2022 that [the Providers] had commenced an action in federal court" and that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." QRS further stated that, based on § 405.1842(h)(3)(i), it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit" and "regret that apparently this did not happen, and we apologize for not doing more to proactively notify the Board regarding the filing of the complaint ourselves."

FSS in its May 5, 2022 response, suggested that QRS' response was disingenuous in presuming that the CMS Office of Attorney Advisor would promptly notify the Board of the Providers' lawsuit, filed by QRS, because QRS had failed to properly serve the Secretary until April 12, 2022 with an alias summons:

> Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a

[66] (Emphasis added.)
[67] (Emphasis added.)

> Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.

The Board subsequently reviewed the preambles to the proposed rule, dated June 5, 2004,[68] and the May 23, 2008 final rule[69] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[70]

The final rule includes additional guidance on § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. We do not agree that it would be appropriate for the Board or the

[68] 69 Fed. Reg. 35716 (June 25, 2004).
[69] 73 Fed. Reg. 30190 (May 23, 2008).
[70] 69 Fed. Reg. at 3572

> intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[71]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' filing of the Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the EJR request for the cases as filed above, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that QRS created the confusion surrounding the status of these cases at the Board. QRS readily admits that, once it filed the Complaint in federal district court on February 14, 2022, they "*reasonably believed that further proceedings before the Board were prohibited by regulation*"[72] and stated that they did not notify the Board of that filing because, based on § 405.1842(h)(3)(i), they "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, the Board finds QRS' reliance on § 405.1842(h)(3)(i) to be misplaced and not made in good faith. Namely, it ignores both the Board's ruling in its January 24, 2022 Scheduling Order and the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[73] QRS had a duty to communicate early and in good faith with the Board and the opposing party (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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[71] 73 Fed. Reg at 30214-15.
[72] (Emphasis added.)
[73] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 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/ReviewBoards/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;
> - 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.[74]

[74] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board.

In response to the Board's April 24, 2022 Order to Show Cause, QRS asserted that "any theory of wholesale abandonment of so many appeals because the Providers decided to pursue those appeals in Federal court under a good faith understanding of the statute's requirement that the Board decides EJR requests within thirty days, and our good faith understanding that the filing of such a complaint halts further action before the Board, would be mistaken." Further, in its response, QRS is quick to assert that 42 U.S.C. § 1395oo(f)(1) obligated the Board (and the Medicare Contractors) to process its EJR request, ***and*** complete its jurisdictional review of those 80 group cases and the underlying 950+ participants, within 30 days of its filing the EJR request (*i.e.*, by Friday February 11, 2022). However, QRS' reliance on this position glosses over the record, and ignores how its silence interfered with the speedy, orderly and fair conduct of the Board proceedings (both in these cases and others) and prejudiced the opposing parties. Indeed, the following inaction on QRS' part belies its claim in the April 8, 2022 notice to the Board that "proceedings before the PRRB have been exhausted":

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' January 20, 2022 motion to extend the Medicare Contractor's time to file jurisdictional challenges until May 5, 2022, more than 3 months after that motion was filed.[75] Indeed, the tardiness of QRS' opposition is highlighted by the fact that it did not make its opposition known until after that extended deadline had passed by more than 50 days. QRS' failure to file notice with the Board, and serve FSS and/or the Medicare Contractors (*i.e.*, the opposing parties), of its opposition to FSS' request, violates QRS' obligations under Board Rules 1.3, 5.2, and 44.

2. QRS did not notify the Board of its objection to the Board's January 24, 2022 ruling on the extension, and the associated Scheduling Order, until May 5, 2022, more than 3 months after the fact. QRS' failure to file and preserve its objection to the Board's January 24, 2022 ruling and Scheduling Order violates QRS' obligations under Board Rules 1.3, 5.2, and 44 and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[76] The tardiness of QRS' opposition is again highlighted by the fact that it failed to make its opposition known until well after the extended deadline they complain of had passed.

Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[75] QRS' April 8, 2022 filing was 3 sentences long and did not provide this notice.

[76] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

3. On January 24, 2022, the Board made its position as to how the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[77] and Board Alert 19, known to the parties in these cases. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. Because the Board was not operating normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Order to memorialize and effectuate the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Board's January 24, 2022 Scheduling Order until May 5, 2022. QRS' failure to timely file, and preserve, that objection violates Board Rules 1.3, 5.2 and 44. QRS' delay also interfered with the speedy, orderly and fair conduct of the Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[78] or take other actions, ***prior to*** Friday, February 11, 2022 (*i.e.*, prior to the end of the alleged 30-day deadline from January 12, 2022). QRS' delay allowed the 30-day EJR review deadline, as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (that QRS now alleges the Board missed), to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[79]

4. In its January 24, 2022 Scheduling Order, the Board set forth its process for conducting jurisdictional review. In addition to specifying time for the Medicare Contractors to file jurisdictional challenges and the Providers to respond to those challenges, the Board included the following directive to the parties to supplement the record in these group cases "*to ensure the record before it in these group cases is* ***complete***"[80]:

> The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board*

[77] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[78] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 5, 2004 proposed rule. *See supra* notes 70 and 71 and accompanying text.
[79] *See supra* note 76 (discussing how the FRCP supports the Board's position).
[80] (Emphasis added.)

> *rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases.*

QRS blatantly disregarded, and failed to address the Board's directive, to supplement the record relative to jurisdiction.[81] *As the overwhelming majority of the 80 group cases* involved participants that transferred from individual cases formed under the legacy docketing system, the Board's directive applied to the great majority of the 80 group cases. The Board agrees with FSS' statement, in its April 18, 2022 Request for Dismissal, that "the Board's Orders are not aspirational and the Providers' basis for disregarding them is unsupported (and unsupportable) by either law or fact."

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). This occurred, despite the fact that, at that point in time, QRS claimed to "reasonably believe[] that further proceedings before the Board were prohibited by [the] regulation" at 42 C.F.R. § 405.1842(h)(3)(iii). QRS points to the statement in 42 C.F.R. § 405.1842(h)(3)(i) that "the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and copy of the compliant." QRS further contends that it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, that does not mean that QRS did not have an affirmative obligation to *promptly* notify the Board of the lawsuit, and a further specific obligation to notify the Board of the lawsuit based on the circumstances of the Board proceedings. The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Order, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Order directed both parties to submit certain jurisdictional related information, over a 90-day time frame, relevant to these 80 group cases and the underlying 950+ participants.

    b. Both the Board and the Medicare Contractors were acting in reliance on the authority of that Scheduling Order.

[81] The Board notes that the Medicare Contractors *did respond* to this portion of the Scheduling Order and *did file* copies of pending/unresolved jurisdictional challenges in individual appeals that impact participants in these 80 group cases. Indeed, the Board believes that it was as a result of this directive that the Medicare Contractors identified previously withdrawn/dismissed providers where challenges in individual appeals had been resolved through dismissal/withdrawal and denial of transfers. *See supra* note 32 and accompanying text.

c. QRS' position is dependent upon promptly effectuating service on the Secretary, and FSS contends that this service was not actually effectuated until on April 12, 2022, more than two months later, when an alias summons was issued.[82]

These circumstances make clear that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty."[83] Indeed, QRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on or about February 14, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay, or cease, work on the 80 group cases and the underlying 950+ participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS and other representatives. Indeed, QRS' two-month delay in notifying the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by QRS to benefit subsequent EJR requests that QRS filed on behalf of other providers between January 24, 2022 and April 8, 2022 (*i.e.*, the date QRS gave notification).[84] In this regard, the Board notes that QRS filed EJR requests covering 36 cases with more than 640 participants in the aggregate,[85] of which the overwhelming majority (*i.e.*, greater than 80 percent of the 640+ participants) is associated with a consolidated EJR request filed on

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[82] FSS letter dated May 9, 2022 (stating: "Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.").

[83] It is disingenuous for QRS to suggest in hindsight in its May 5, 2022 response to the Board's April 24, 2022 Order to Show Cause that "[t]he Providers did not respond to the Board's deadlines or to the MAC's filings because [on February 14, 2022] the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that "[t]he Providers notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court" but "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." The Board made its position known in its January 24, 2022 Notice of Stay and Scheduling Order and to the extent QRS had any doubts it had an obligation to seek clarification from the Board. Again, the Board's January 24, 2022 Notice of Stay and Scheduling Order was not aspirational and the Providers' basis for disregarding it is unsupported (and unsupportable) by either law or fact.

[84] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

[85] On February 11, 2022, QRS filed a consolidated EJR request covering 10 group cases with 46 participants, in the aggregate. On February 27, 2022, QRS filed a consolidated EJR request covering 12 group cases with roughly 520 participants, in the aggregate. On March 9, 2022, QRS filed a consolidated EJR request covering 14 group cases with 76 participants, in the aggregate.

February 17, 2022[86] just days after the February 14, 2022 lawsuit was filed.[87] To this point, it is the Board's understanding that, ***prior to*** *the April 8, 2022 notice*, QRS filed an Amended Complaint on March 30, 2022 incorporating these other EJR requests into the lawsuit pending in the California Central District Court (or into new sister lawsuits filed therein).[88] Moreover, it is the Board's understanding that another representative, Healthcare Reimbursement Services, Inc. ("HRS") contemporaneously filed consolidated EJR requests covering 120 group cases with 569 participants in the aggregate,[89] and has joined QRS in lawsuits filed in the California Central District Court, including the one involved with the instant 80 group cases.[90]

As part of its April 8, 2022 notice to the Board, QRS clearly stated that it was abandoning the Board's jurisdictional review process and not complying with the Board's January 24, 2022 Scheduling Order when they stated in their April 8, 2022 filing: "*the Providers consider that proceedings before the PRRB have been* ***exhausted***[and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[91] Further, it is clear the Providers are pursuing the merits of their cases as part of the lawsuit. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[92]

However, the Board cannot permit QRS' reckless disregard for its ***basic*** responsibilities and due diligence, as a representative appearing before the Board (including but not limited to failure to track and account for withdrawn/dismissed providers), its abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, if these cases are remanded, the Board will complete its jurisdictional review and weigh the severity of QRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the

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[86] The January 17, 2022 consolidated EJR request covers 12 cases: Case Nos. 13-2324GC, 13-2328GC, 14-1072GC, 14-1073GC, 15-0580GC, 15-0586GC, 15-1622GC, 15-1624GC, 16-0678GC, 16-0679GC, 17-0575GC, and 17-0577GC.
[87] QRS waited until May 19, 2022 to file notice to the Board and the opposing parties that it had filed a lawsuit covering the 12 group cases covered by the February 17, 2022 consolidated EJR request.
[88] The Board will be addressing the status of these other cases under separate cover shortly.
[89] On December 29, 2021, HRS filed a consolidated EJR request covering 63 group cases with 255 participants, in the aggregate. On January 17, 2022, HRS filed a consolidated EJR request covering 40 cases with 200 participants, in the aggregate. On February 27, 2022, HRS filed a consolidated EJR request covering 17 group cases with 114 participants, in the aggregate.
[90] The Board will be addressing the status of these other cases under separate cover shortly.
[91] Board Scheduling Order at n.23 (Apr 21, 2022) (emphasis added).
[92] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

effect on the operations of the Board, when determining what, if any, remedial actions will be taken. Examples of available remedial actions that the Board may consider include, but are not limited to:

1. Dismissal of the 80 group cases and all underlying participants.
2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.
3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[93] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
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> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the

[93] 42 C.F.R. § 405.1868 states:

(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.

(Emphasis added.)

> authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[94]

* * * * *

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[95] Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
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[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

09-1903GC	BHCS 07 DSH Dual Eligible Days
13-1419G	QRS 2006 DSH SSI Fraction Denominator/Dual Eligible Group
13-1440G	QRS 2006 DSH Medicaid Fraction/Dual Eligible Group
13-1720GC	Scott & White 2008 Medicaid Fraction Dual Elig Days CIRP Group
13-1722GC	Scott & White 2008 DSH SSI Fraction Dual Elig Days CIRP Group
13-2678G	QRS 2007 DSH Medicaid Fraction Dual Eligible Days Group (2)
13-2693G	QRS 2008 DSH Medicaid Fraction Dual Eligible Days Group
13-2901GC	QRS BJC 2007 DSH SSI Fraction Dual Eligible Days CIRP Group
13-2903GC	QRS Novant 2007 SSI Fraction Dual Eligible Days CIRP Group
13-2904GC	QRS Novant 2007 Medicaid Fraction Dual Eligible Days CIRP Group
13-3061GC	QRS WFHC 2009 Medicaid Fraction Dual Eligible CIRP Group
13-3191GC	QRS Novant 2006 DSH Dual Eligible Days
13-3942G	QRS 2009 DSH Medicaid Fraction/Dual Eligible Days Group
13-3944G	QRS 2009 DSH SSI Fraction/Dual Eligible Days Group
14-1171G	QRS 2008 DSH SSI Fraction Dual Eligible Days Group
14-1174G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group
14-1816G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group
14-1818G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group
14-2217GC	QRS Novant 2009 DSH Medicaid Fraction Dual Eligible Days CIRP Group
14-3306G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group
14-3308G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group
15-0018G	QRS 2012 DSH Medicaid Fraction/Dual Eligible Days Group
15-1067G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group (2)
15-1147G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group (2)
15-1152GC	QRS Novant 2010 DSH Medicaid Fraction Dual Eligible Days CIRP Group
15-1419G	QRS 2012 DSH SSI Fraction Dual Eligible Days Group
15-2385G	QRS 2010 DSH SSI Fraction Dual Eligible Days Group II
15-2386G	QRS 2010 DSH Medicaid Fraction Dual Eligible Days Group II
15-3031G	QRS 2011 DSH Medicaid Fraction Dual Eligible Days Group 2
15-3039G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group 2
15-3073GC	QRS Progressive Acute Care 2011 DSH Medicaid Fraction/Dual Eligible Days
16-0091GC	HRS DCH 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
16-0092GC	HRS DCH 2010 Medicaid Fraction Dual Eligible Days CIRP Group
16-1142G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group
16-1145G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group
16-1750G	QRS 2012 DSH SSI/Medicaid Dual Eligible Days Group II
17-0867G	QRS 2014 DSH SSI/Medicaid Dual Eligible Days Group
17-1405G	QRS 2013 DSH SSI Fraction Dual Eligible Days Group (2)
17-1406G	QRS 2013 DSH Medicaid Fraction Dual Eligible Days Group (2)
17-1409G	QRS 2005 DSH SSI Fraction Dual Eligible Days Group
17-1412G	QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group
17-1426G	QRS 2006 DSH SSI Fraction Dual Eligible Days Group 3

17-1427G	QRS 2006 DSH Medicaid Fraction Dual Eligible Days Group
18-0270G	QRS 2007 DSH SSI Fraction Dual Eligible Days Group (3)
18-0730G	QRS 2011 DSH SSI Fraction Dual Eligible Days Group III
18-1259G	QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
18-1260G	QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2
18-1405G	QRS 2015 DSH Medicaid Fraction Dual Eligible Days Group
18-1408G	QRS 2015 DSH SSI Fraction Dual Eligible Days Group
18-1738GC	AHMC Healthcare CY 2012 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0012GC	AHMC Healthcare CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0014GC	AHMC Healthcare CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0164GC	AHMC Healthcare CY 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0195GC	Houston Methodist CY 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0235GC	Houston Methodist CY 2014 DSH Medicaid Fraction Dual Eligible Days CIRP
19-0270GC	Mercy CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-0272GC	Mercy CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group
19-0534G	QRS CY 2011 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-0704G	QRS CY 2012 DSH SSI Fraction Dual Eligible Days (3) Group
19-0706G	QRS CY 2012 DSH Medicaid Fraction Dual Eligible Days (3) Group
19-2131GC	Hartford Health CY 2015 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2134GC	Hartford Health CY 2015 DSH Medicaid Fraction Dual Eligible Days CIRP
19-2513G	QRS CY 2016 DSH SSI Fraction Dual Eligible Days Group
19-2515G	QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group
19-2594G	QRS CY 2015 DSH SSI Fraction Dual Eligible Days (2) Group
19-2596G	QRS CY 2015 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0107G	QRS CY 2013 DSH SSI Fraction Dual Eligible Days (3) Group
20-0112G	QRS CY 2013 DSH Medicaid Fraction Dual Eligible (3) Group
20-0209G	QRS CY 2010 DSH SSI Fraction Dual Eligible Days (3) Group
20-0211G	QRS CY 2010 DSH Medicaid Fraction Dual Eligible (3) Group
20-0244G	QRS CY 2007 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0248G	QRS CY 2006 DSH SSI Fraction Dual Eligible Days (4) Group
20-0250G	QRS CY 2006 DSH Medicaid Fraction Dual Eligible Days (4) Group
20-0367G	QRS CY 2005 DSH SSI Fraction Dual Eligible Days (2) Group
20-0368G	QRS CY 2005 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-0409GC	AHMC Healthcare CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
20-0411GC	AHMC Healthcare CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP
20-1511G	QRS CY 2014 DSH SSI Fraction Dual Eligible Days (2) Group
20-1513G	QRS CY 2014 DSH Medicaid Fraction Dual Eligible Days (2) Group
20-1655G	QRS CY 2007 DSH SSI Fraction Dual Eligible Days (4) Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

David Johnston, Esq.
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215

RE: ***Notice of Dismissal***
Holzer Medical Center (Prov. No. 36-0054)
FYE 06/30/2015
Case No. 18-0858

Dear Mr. Johnston:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Holzer Medical Center's ("Provider") Individual Appeal Request on February 14, 2018. On March 25, 2020, the Board issued Alert 19, which indefinitely suspended "Board-Set Deadlines" from Friday, March 13, 2020 forward and also "encourage[d] Providers and their representatives to continue to make these filings electronically through OH CDMS, as appropriate and in keeping with public health precautions."[1]

On July 26, 2021, the Board issued a Notice of Hearing for the above referenced appeal, setting the hearing date for April 29, 2022. On August 5, 2022, after attempting to contact the representative to no avail, a Notice of Potential Dismissal was issued to the Provider with the following Order:

> Based on the failure of the Provider's Representative to respond to any of the Board's direct inquiries and the lack of any contact with the Board since filing its Preliminary Position Paper in 2018 (including but not limited to responding to the Notice of Hearing or appearing for the April 29, 2022 hearing), the Board hereby orders the Provider's Representative to file ***within fifteen (15) days of this letter's signature date*** a case status update and, in particular, to advise whether the Provider is still pursuing this appeal.[1]

The Order further stated that "*Be advised that this filing deadline is **firm** and the Board has determined to specifically **exempt** this filing deadline from Board Alert 19's suspension of Board filing deadlines*"[2] and that "[f]ailure to submit a timely response to this request will result in dismissal of the case." As of the date of this letter, no response has been submitted by the Provider's representative.

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

Pursuant to 42 C.F.R. § 405.1868(a)-(b):

> (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.[3]

Having issued an Order requiring the Provider's representative "to file. . . a case status update and, in particular, to advise whether the Provider is still pursuing the appeal," having exempted that deadline from the Alert 19 suspension of Board-set deadlines, and having received no response (before or after that deadline), it is clear the Provider has failed to comply with the Board Order. Further, having received no response or any other filing or inquiry to date, the Board must conclude the appeal is abandoned. Accordingly, pursuant to its authority under 42 C.F.R. § 405.1868, 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:

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

For the Board:

10/21/2022

X Clayton J. Nix

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

cc: Joseph S. Bauers, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)
David Johnston at DJohnston@ebglaw.com

[3] *See also* Board Rules 4.1 & 41.2

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Robert Roth, Esq.
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Pamela VanArsdale
National Government Services, Inc. (J-6)
Mail point INA101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

RE: **Board Determination on Consolidation Request**

University of Chicago Hospitals (Prov. No. 14-0088) FYE 6/30/2009
Original NPR Appeal - PRRB Case No. 14-2637
Revised NPR Appeal - PRRB Case No. 23-0014

Dear Mr. Roth and Ms. VanArsdale:

The Provider Reimbursement Review Board (the "Board") has reviewed correspondence from Hooper, Lundy & Bookman, PC ("Hooper Lundy" or "Representative"), dated October 7, 2022, in which it requests the consolidation of the above-referenced group appeals. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On February 25, 2014, Hooper Lundy filed an appeal for the University of Chicago Hospitals for FYE 06/30/2009 from receipt of its original Notice of Program Reimbursement ("NPR") under Case No. 14-2637. The appeal included various issues, including the "New Residency Training Program" issue. On January 26, 2022 the Medicare Contractor finalized a full administrative resolution of all of the issues in Case No. 14-2637 and the case was closed on January 27, 2022.

In the full administrative resolution, the Medicare Contractor indicated that a revised NPR ("RNPR") for the "New Residency Training Program" issue would be issued within 180 days of the signed administrative resolution. On April 8, 2022 the Medicare Contractor issued the RNPR for the issue, which the Provider appealed on October 4, 2022. At the time of the RNPR appeal, the original NPR case under Case No. 14-2637 was still in a closed status, although a reinstatement had been requested.[1] Therefore, a new appeal was filed from receipt of the RNPR and a new case was established under Case No. 23-0014. The sole issue in Case No. 23-0014 is "DGME & IME Payments–New Residency Programs–Prior Year ("PY") and Penultimate Year ("PULTY").

[1] Hooper Lundy filed a request for reinstatement on August 31, 2022.

On October 5, 2022, the Board reinstated Case No. 14-2637, for the DSH Medicaid Eligible Patient Days issue. The reinstatement resulted in two pending appeals for the Provider for the same cost reporting period.

On October 7, 2022 Hooper Lundy requested the consolidation of the two cases. The Representative indicates that the Medicare Contractor objects to the consolidation " . . . on the basis that the IME & DGME PY and PPY FTEs carryforward issues were not adjusted on the 4/8/2022 RNPR, and thus were improperly added in 23-0014."

Board Determination:

It is the Board's policy to establish only one (1) appeal per Provider per fiscal year end. Board Rule 4.6.2 indicates "[a]ppeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal." Accordingly, the Board is exercising its discretion and hereby consolidates the RNPR appeal for University of Chicago Hospitals under Case No. 23-0014 into the recently reinstated original NPR appeal under Case No. 14-2637.[2] Case No. 23-0014 is hereby closed and removed from the Board's docket. The Board notes the Medicare Contractor's objection, and the Medicare Contractor should formally file an official objection in the reinstated consolidated appeal.

The Parties will receive a new Critical Due Dates notification for Case No. 14-2637 under separate cover. *Be advised that **the filing deadlines in that notification are firm** as the Board has determined to specifically exempt it from Board Alert 19's suspension of Board filing deadlines. As a result, failure to respond by the filing deadlines in the notification may result in dismissal of the appeal.*

Board Members:
Clayton R. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

10/24/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
Board Member
Signed by: Kevin D. Smith -A

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

[2] The Board is aware that, according to the Representative's correspondence, the Medicare Contractor has objected to the consolidation of the RNPR appeal into Case No. 14-2637. If the Medicare Contractor continues to object to the issue appealed from the RNPR, it must file such objection in the surviving case in the Office of Hearings & Case Document Management System ("OH CDMS") before the Board will address the challenge.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich, Esq.
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1700 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Dismissal For Lack of Jurisdiction***
CHRISTUS 2017-2020 CJR Final Rule CIRP
Case No. 16-1721GC

Dear Mr. Hettich,

This case involves the Providers' appeal of the final rule published on November 24, 2015 implementing the Comprehensive Care for Joint Replacement ("CJR") model.[1] This final rule will hereinafter be referred to as the "CJR 2015 Final Rule." The Providers assert that the CJR model as published in the CJR 2015 Final Rule is contrary to statute or otherwise prohibited by law.[2] The Providers have filed this timely[3] appeal from a Federal Register notice, which is a final determination,[4] and the amount in controversy exceeds the $50,000 requirement for a group appeal.[5]

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' Response to the Board's Request for Comments and Notice of Potential Own Motion Expedited Judicial Review ("EJR") of the issue on appeal.[6] Following review of the Providers' arguments as well as the documentation in the administrative record, the Board finds that its review of the issue of this case is prohibited by statute and, thus, lacks jurisdiction over the group appeal. Accordingly, as set forth below, the Board dismisses the case pursuant to 42 C.F.R. §§ 405.1840(a)(4), (c)(2).

Background:

The CJR 2015 Final Rule implements a new Medicare Part A and B payment model under 42 U.S.C. § 1315a, called the CJR model in which acute care hospitals in certain selected geographic areas receive retrospective bundled payments for episodes of care for lower extremity joint

[1] 80 Fed. Reg. 73273 (Nov. 24, 2015).
[2] Providers' Hearing Request, Tab 2 (May 23, 2016) (Statement of the Issue).
[3] The hearing request was received on a Monday that was 181 days after the publication of the Final Rule. Pursuant to 42 C.F.R. § 405.1801(d)(3), if the last day of the appeal period is a Sunday, the deadline becomes the next day.
[4] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015); 42 C.F.R. § 405.1837.
[5] 42 C.F.R. § 405.1839(b).
[6] Although the Board requested comments from ***both*** parties**, it** did not receive a response to its Request for Comments from the Medicare Contractor.

replacement ("LEJR") or reattachment of a lower extremity.[7] All related care within 90 days of the hospital discharge from the joint replacement procedure is included in the episode of care. The Secretary believes this model will further her goals in improving the efficiency and quality of care for Medicare beneficiaries with these common medical procedures.[8]

The statute, 42 U.S.C. § 1315a, authorizes the Center for Medicare and Medicaid Innovation ("CMMI") to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of patient care. The intent of the CJR model is to promote quality and financial accountability for episodes of care surrounding a LEJR or reattachment of a lower extremity procedure.[9]

The Secretary anticipated that the CJR model would benefit Medicare beneficiaries by improving the coordination and transition of care, improving the coordination of items and services paid for through Medicare Fee-For-Service ("FFS"), encouraging more provider investment in infrastructure and redesigned care processes for higher quality and more efficient service delivery, and incentivizing higher value care across the inpatient and post-acute care ("PAC") spectrum spanning the episode of care. The Centers for Medicare & Medicaid Services ("CMS") initially tested the model for five (5) performance periods which began April 1, 2016 and end December 31, 2020.

Under FFS, Medicare makes separate payments to providers and suppliers for the items and services furnished to a beneficiary over the course of treatment (an episode of care). With the amount of payments dependent on the volume of services delivered, providers may not have incentives to invest in quality improvement and care coordination activities. As a result, care may be fragmented, unnecessary, or duplicative.[10]

The Secretary believes the CJR model furthers the mission of CMMI and her goal of increasingly paying for value rather than for volume, because it promotes the alignment of financial and other incentives for all health care providers and suppliers caring for a beneficiary during an LEJR episode. In the CJR model, the acute care hospital that is the site of surgery is held accountable for spending during the episode of care.[11]

Participant hospitals are given the opportunity to earn performance-based payments by appropriately reducing expenditures and meeting certain quality metrics. They also gain access to data and educational resources to better understand LEJR patients' PAC needs and associated spending. The Secretary believes that payment approaches that reward providers that assume financial and performance accountability for a particular episode of care create incentives for the implementation and coordination of care redesign between hospitals and other providers and suppliers.[12]

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[7] Hip and knee replacements are the focus of the model. *See* 80 Fed. Reg. 41198, 41212 (July 14, 2015) (proposed rule).
[8] 80 Fed. Reg. 73274 (Nov. 24, 2015).
[9] 80 Fed. Reg. at 73276.
[10] *Id.*
[11] *Id.*
[12] *Id.*

The Secretary believes this model allows CMS to gain experience with making bundled payments to hospitals who have a variety of historic utilization patterns; different roles within their local markets; various volumes of services; different levels of access to financial, community, or other resources; and various levels of population and health provider density including local variations in the availability and use of different categories of PAC providers. The Secretary believes that by requiring the participation of a large number of hospitals with diverse characteristics, the CJR model results in a robust data set for evaluation of this bundled payment approach, and stimulates the rapid development of new evidence-based knowledge. Testing the model in this manner also allows CMS to learn more about patterns of inefficient utilization of health care services and how to incentivize the improvement of quality for common LEJR procedure episodes.[13]

The CJR 2015 Final Rule implemented a model focused on episodes of care for LEJR procedures. The Secretary chose LEJR episodes for the CJR model because these are high-expenditure, high utilization procedures commonly furnished to Medicare beneficiaries, where significant variation in spending for procedures is observed. The Secretary believes that the high volume of episodes and variation in spending for LEJR procedures creates a significant opportunity to test and evaluate the CJR model that specifically focuses on a defined set of procedures. Moreover, there is substantial regional variation in PAC referral patterns and the intensity of PAC provided for LEJR patients, thus resulting in significant variation in PAC expenditures across LEJR episodes initiated at different hospitals.[14]

The Secretary posits that the CJR model enables hospitals to consider the most appropriate PAC for their LEJR patients. The CJR model additionally offers hospitals the opportunity to better understand their own processes with regard to LEJR, as well as the processes of post-acute providers. Finally, while many LEJR procedures are planned, the CJR model provides a useful opportunity to identify efficiencies both for when providers can plan for LEJR procedures and for when the procedure must be performed urgently.[15]

In comments to the final rule, relevant here, commenters questioned the Secretary's required participation in a payment model. Commenters stated that the Secretary lacks the legal authority to compel participation in a model, and that the Secretary misreads 42 U.S.C. § 1315a(a)(5) as the legal basis for compelling providers in selected Metropolitan Statistical Areas (MSAs) to participate in the CJR model. A commenter stated that language in the statute has never been interpreted to afford the Secretary the authority to compel provider participation in a Medicare demonstration project or model, and that Congress intended for model tests to be voluntary, not mandatory, when authorizing CMS to test new models. The commenter noted that requiring providers to participate in a model that would encompass a substantial proportion of a particular service would render the statutory distinction between testing and expanding models meaningless. The commenter also expressed concern about the model's potential effect on beneficiaries' appeal rights.[16]

[13] *Id.* at 73276-77.
[14] *Id.* at 73277.
[15] *Id.*
[16] *Id.*

Several commenters stated that CMS is sidestepping the legal safeguards designed to prevent the Agency from imposing novel or haphazard models on providers prior to adequate testing and evaluation. The commenters also claimed that CMS had exceeded its statutory authority because under 42 U.S.C. § 1315a, providers are precluded from appealing their selection in a model, raising further concern that CMS is overreaching by requiring participation in the CJR model. Commenters also noted that there is no precedent for a CMS demonstration or model that requires providers to participate. Finally, several commenters stated that CMS has reversed the intended sequence of testing and then expanding models.[17]

The Secretary disagreed with commenters that she lacks the legal authority to test the CJR model as proposed and specifically, to require the participation of selected hospitals. The Secretary noted that although CJR will be the first Innovation Center model in which acute care hospitals are required to participate, the 2016 Home Health Prospective Payment System (HHPS) Final Rule finalized the Home Health Value-Based Purchasing (HHVBP) model that home health agencies in selected states will be required to participate beginning in January 2016. The Secretary believes that both § 1315a and her existing authority to operate the Medicare program authorize the CJR model as proposed, and finalized the regulations.[18]

The Secretary pointed out that § 1315a authorizes her to test payment and service delivery models intended to reduce Medicare costs while preserving quality. The statute does not require that models be voluntary, but rather gives the Secretary broad discretion to design and test models that meet certain requirements as to spending and quality. Although § 1315a(b) describes a number of payment and service delivery models that the Secretary may choose to test, the Secretary does not believe that she is limited to those models. Rather, models to be tested under § 1315a must address a defined population for which there are either deficits in care leading to poor clinical outcomes or potentially avoidable expenditures. Here, the CJR model addresses a defined population (FFS Medicare beneficiaries undergoing LEJR procedures) for which there are potentially avoidable expenditures (arising from less than optimal care coordination).[19]

The Secretary determined that it is necessary to test this model among varying types of hospitals that have not chosen to voluntarily participate in another episode payment model, such as Bundled Payments for Care Improvement ("BPCI"). As noted in the final rule, the Secretary is testing an episode approach for LEJR episodes through the voluntary BPCI models. The Secretary designed the CJR model to require participation by hospitals in order to avoid the selection bias inherent to any model in which providers may choose whether to participate. Such a design will allow for testing of how a variety of hospitals will fare under an episode payment approach, leading to a more robust evaluation of the model's effect on all types of hospitals. The Secretary believes this is the most prudent approach for the following reasons:

- The information gained from testing of the CJR model will allow CMS to more comprehensively assess whether LEJR episode payment models are appropriate for any potential national expansion.

[17] *Id.*
[18] *Id.* at 73277-78.
[19] *Id.*

- Under CJR, CMS will have tested and evaluated such a model across a wide range of hospitals representing varying degrees of experience with episode payment.

- The Secretary believes it is important to gain knowledge from a variety of perspectives in considering whether and which models merit national expansion.

The Secretary asserted that the above rationale demonstrated that the CJR model meets the criteria required for initial test models.[20]

Further, the Secretary pointed out that she has the authority to establish regulations to carry out the administration of Medicare. Specifically, the Secretary has authority under 42 U.S.C §§ 1302 and 1395hh to implement regulations necessary to administer Medicare, including testing this Medicare payment and service delivery model. The Secretary noted that while CJR will be a model, and not a permanent feature of the Medicare program, the model will test different methods for delivering and paying for services covered under the Medicare program, which the Secretary has legal authority to regulate.[21]

A. Retrospective Payment Methodology

An episode in the CJR model begins with the admission for an anchor hospitalization and ends 90 days post-discharge from the anchor hospitalization, including all related services covered under Medicare Parts A and B during this timeframe.[22]

The CJR episode payment methodology is retrospective. All providers and suppliers caring for Medicare beneficiaries in CJR episodes continue to bill and be paid as usual under the applicable Medicare payment system. After the completion of a CJR performance year, Medicare claims for services furnished to beneficiaries in that year's non-cancelled episodes are grouped into episodes and aggregated, and participant hospitals' CJR episode quality and actual payment performance are assessed and compared against episode quality thresholds and target prices.[23]

After the participant hospitals' actual episode performance in quality and spending are compared against the episode quality thresholds and target prices, CMS determines if Medicare would make a payment to the hospital (reconciliation payments), or if the hospital owes money to Medicare (resulting in Medicare repayment). Participant hospitals were not subject to repayment for performance year one.[24]

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[20] *Id.*
[21] *Id.*
[22] 80 Fed. Reg. 41196, 41219 (July 14, 2015).
[23] *Id*. at 41220.
[24] *Id.*

Participant hospitals would qualify for reconciliation payments if episode actual spending was less than the episode target price, but would not be required to make repayments to Medicare if episode actual spending was greater than the episode target price. However, the Secretary believes not holding hospitals responsible for repaying excess episode spending would reduce the incentives for hospitals to improve quality and efficiency.[25]

To further ensure hospital readiness to assume responsibility for circumstances that could lead to a hospital repaying to Medicare actual episode payments that exceed the episode target price, the Secretary will begin to phase in this responsibility for performance year 2, with full responsibility for excess episode spending applied for performance year 3 through performance year 5. To carry out this ''phase in'' approach, the Secretary proposed during the first year of any hospital financial responsibility for repayment (performance year 2) to set an episode target price that partly mitigates the amount that hospitals would be required to repay.[26]

B. Limitations on Matters that May be Reviewed

42 C.F.R. § 405.1840 addresses Board jurisdiction and sets forth the following criteria for determining Board jurisdiction:

> (b) *Criteria*. Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837 of this subpart, as applicable. **Certain matters at issue are removed from jurisdiction of the Board**. **These matters include, but are not necessarily limited to, the following**:
>
> (1) A finding in a contractor determination that expenses incurred for certain items or services furnished by a provider to an individual are not payable under title XVIII of the Act because those items or services are excluded from coverage under section 1862 of the Act and part 411 of the regulations. Review of these findings is limited to the applicable provisions of sections 1155, 1869, and 1879(d) of the Act and of subpart I of part 405 and subpart B of part 478 of the regulations, as applicable.

[25] *Id.*
[26] *Id.*

> (2) Certain matters affecting payments to hospitals under the prospective payment system, as provided in section 1886(d)(7) of the Act and § 405.1804 of this subpart.

Accordingly, § 405.1840(b) recognizes that certain matters are *removed* from the jurisdiction of the Board.

42 U.S.C. § 1315a(d) provides that certain matters involving models are removed from the jurisdiction of the Board. In this regard, § 1315a(d)(2) addresses "Limitations on review" as follows:

> There is no administrative or judicial review under section 1395ff of this title, section 1395oo of this title, or otherwise of –
>
> A. the selection of models for testing or expansion under this section;
>
> B. the selection of organizations, sites, or participants to test those models selected;
>
> C. the elements, parameters, scope, and duration of such models for testing or dissemination;
>
> D. determinations regarding budget neutrality under subsection (b)(3);
>
> E. the termination or modification of the design and implementation of a model under subsection (b)(3)(B);
>
> F. determinations about expansion of the duration and scope of a model under subsection (c), including the determination that a model is not expected to meet criteria described in paragraph (1) or (2) of such subsection.[27]

As part of the CJR 2015 Final Rule, the Secretary implemented this limitation on review at 42 C.F.R. § 510.310(e) which states:

> (e) *Limitations on review*. In accordance with section 1115A(d)(2) of the Act, there is no administrative or judicial review under sections 1869 or 1878 of the Act or otherwise for the following:
>
> (1) The selection of models for testing or expansion under section 1115A of the Act.

[27] *See also id.* at 73409 (referring to the corresponding statutory provisions in 42 U.S.C. § 1315a which is also referred to as § 1115A of the Social Security Act.)

> (2) The selection of organizations, sites, or participants to test those models selected.
>
> (3) The elements, parameters, scope, and duration of such models for testing or dissemination.
>
> (4) Determinations regarding budget neutrality under section 1115A(b)(3) of Act.
>
> (5) The termination or modification of the design and implementation of a model under section 1115A(b)(3)(B) of Act.
>
> (6) Decisions about expansion of the duration and scope of a model under section 1115A(c) of the Act, including the determination that a model is not expected to meet criteria described in section 1115A(c)(1) or (2) of the Act.[28]

C. CJR Matters That Are Not Precluded from Review

As part of the CJR 2015 Final Rule, the Secretary also finalized her proposal, without modification, regarding the matters subject to dispute resolution, and the process CMS will use to adjudicate dispute resolution matters. Thus, a participant hospital may appeal an initial determination *that is not precluded from administrative or judicial review* by requesting reconsideration review by a CMS official. The request for review must be submitted for receipt by CMS within 10 days of the notice of the initial determination, in a form and manner specified by CMS. Only a participant hospital may utilize the dispute resolution process.[29]

In order to access the dispute resolution process, a participant hospital must timely submit a calculation error form for any matters related to payment. These matters include any amount or calculation indicated on a CJR reconciliation report, including calculations not specifically reflected on a CJR reconciliation report but which generated figures or amounts reflected on a CJR reconciliation report. The following is a non-exhaustive list of the matters that the Secretary is requiring must be first adjudicated by the calculation error process as previously detailed:

- Calculations of reconciliation or repayment amounts;
- calculations of NPRA [net payment reconciliation amount]; and

[28] While the Secretary initially codified the limitations on review of the CJR model at 42 C.F.R. § 510.310(d) (80 Fed. Reg. at 73546), the Secretary later redesignated subsection (d) as subsection (e) and "correct[ed] a technical error" in paragraph (6) which is not relevant to this appeal (82 Fed. Reg. 180, 528, 615 (Jan. 3, 2017)).
[29] 80 Fed. Reg. at 73411. *See also* 42 C.F.R. § 510.310 (appeals process).

- any calculations or percentile distribution involving quality measures that the Secretary proposed could affect reconciliation or repayment amounts.[30]

If a participant hospital wants to engage in the dispute resolution process with regard to one of these matters, the participant hospital must first submit a calculation error form. Where the participant hospital does not timely submit a calculation error form, the dispute resolution process is not available to the participant hospital with regard to those matters for the reconciliation report for that performance year.[31]

If the participant hospital does timely submit a calculation error form and the participant hospital is dissatisfied with CMS's response to the participant hospital's calculation error form, the hospital is permitted to request reconsideration review by a CMS reconsideration official. The reconsideration review request must be submitted in a form and manner and to CMS. The reconsideration review request must provide a detailed explanation of the basis for the dispute and include supporting documentation for the participant hospital's assertion that CMS or its representatives did not accurately calculate the NPRA or post-episode spending amount in accordance with CJR rules. The following is a non-exhaustive list of representative payment matters:

- Calculations of NPRA, post-episode spending amount, target prices or any items listed on a reconciliation report.
- The application of quality measures to a reconciliation payment, including the calculation of the percentiles thresholds of quality measure performance to determine eligibility to receive reconciliation payments, or the successful reporting of the voluntary PRO THA/TKA [patient reported outcomes total hip arthroplasty/total knee arthroplasty] data to adjust the reconciliation payment.
- Any contestation based on the grounds that CMS or its representative made an error in calculating or recording such amounts.[32]

Lastly, the Secretary finalized her proposal without modification that the reconsideration review is an on-the-record review (a review of briefs and evidence only). The CMS reconsideration official will make reasonable efforts to notify the hospital in writing within 15 calendar days of receiving the participant hospital's reconsideration review request of the date and time of the review, the issues in dispute, the review procedures, and the procedures (including format and deadlines) for submission of evidence (the ''Scheduling Notice''). The CMS reconsideration official will make reasonable efforts to schedule the review to occur no later than 30 calendar days after the date of the Scheduling Notice. The provisions at §§ 425.804(b), (c), and (e) will apply to reviews conducted pursuant to the reconsideration review process for CJR.[33]

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[30] *Id.*
[31] *Id.*
[32] *Id.* at 73,411-12.
[33] *Id*. at 73,412.

The CMS reconsideration official will make reasonable efforts to issue a written determination within 30 days of the review. The determination will be final and binding. This modification is set forth in § 510.310(a)(1). The remainder of the proposal is finalized as proposed and set forth in § 510.310.[34]

Providers' Position:[35]

42 C.F.R. § 405.1837(c)(1) specifies that a group hearing request must include "[a] demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" which includes that the requirement that each participant "satif[y] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement . . . ."

In their hearing request, the Providers contend that, among other things, CMS does not have the authority, under 42 U.S.C. § 1315a, to create a *mandatory* bundled payment program, such as the CJR program at issue here. The Providers assert that the Secretary's allegedly broad interpretation of the authority granted to her under § 1315a violates the non-delegation doctrine which prohibits unconstitutional delegations of Constitutional authority. The Providers believe that statutes should be interpreted, whenever possible, in a way that does not create constitutional issues and that the Secretary's expansive interpretation must be invalidated. The Providers argue that, since the Secretary acted outside of her authority (*i.e.*, *ultra vires*) and the CJR program is not the type of program authorized under § 1315a, the preclusion of review provisions found in § 1315a(d)(2) do not apply.

The Providers explain that § 1315a establishes within CMS, the CMMI for the purpose of testing "innovative" payment and service delivery models. Citing that authority, CMS implemented the CJR program. This five-year program requires nearly 800 hospitals within 67 designated MSAs to accept bundled payments for LEJR surgeries performed on Medicare beneficiaries. Under this model, participating hospitals will be held accountable for the cost of care from the time of surgery until 90 days after discharge. The Providers claim that under this model, if Medicare's actual 90-day episode of care spending for a hospital's LEJR cases exceeds a certain threshold, the hospital will be penalized up to 5 percent in the earlier years of the program, and as high as 10 percent in later years.[36]

The Providers contend that CMS' promulgation of the CJR program is contrary to the statute and otherwise prohibited by law. They argue that the Secretary has no authority to mandate participation in § 1315a bundled payment models because if it did 42 U.S.C. § 1395cc-4, which requires the Secretary to implement a *voluntary* national pilot program to test payment bundling models, would be rendered superfluous. The Providers believe that Congress would not go out of its way to implement a voluntary payment bundling program while giving the Secretary authority to sidestep that restriction in § 1315a and enact a mandatory program.

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[34] *Id.*
[35] Providers' Hearing Request, Tab 2.
[36] 80 Fed. Reg. at 73,326.

Further, the Providers assert the Secretary's interpretation of § 1315a as allowing her to create a mandatory bundling payment program encompassing two of the most common procedures in Medicare creates a violation of the non-delegation doctrine by presuming an unconstitutional delegation of legislative authority. Since the preclusion of review provisions, such as the one contained in § 1315a, heighten the danger of a violation of the non-delegation doctrine, the Secretary must be particularly circumspect in the interpretation of how much latitude § 1315a gives to "legislate" on Congress' behalf.

Finally, notwithstanding the instructions in 42 C.F.R. § 405.1837(c)(1), the hearing request did not address whether the Board had substantive jurisdiction and whether § 1315a(d)(2) precludes Board review of the Providers' appeal.[37]

Board's Request for Comment and Providers' Response:

On December 30, 2021, the Board requested that the parties discuss their respective positions on whether, given the statutory preclusions, listed above, the Board has jurisdiction over the matter at issue and, if there is jurisdiction, whether EJR is appropriate given that it appears as if the Providers are challenging the substantive validity of the CJR Payment Model final rule published on November 24, 2015. The Board also requested that the parties address whether there is any guidance from the Secretary and/or CMS to implement 42 U.S.C. § 1315a(d)(2).

The Board received a response from only the Providers and their response was filed on January 31, 2022. In their response, the Providers argue that 42 U.S.C. § 1315a(d)(2) does *not* preclude review of the matter at issue. Specifically, the Providers argue that § 1315a(d)(2) precludes Board review of a specifically enumerated list of issues (and lists those, as quoted above) and contends that none of those enumerated topics describe the matter at issue – whether CMS has authority in the first instance to *mandate participation* in payment models established pursuant to § 1315a.

The Providers further explain their position as follows:

> Courts have held that unless a statutory prohibition against review is clear, the presumption is that Congress intended to permit administrative and judicial review. While an agency generally is granted great deference in its interpretation of statutes it is charged with administering, special rules apply before an agency can claim that its actions are not subject to judicial oversight. In particular, there is a "strong presumption that Congress intends judicial review of administrative action." *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667, 670 (1986). "This presumption applies even where . . . the statute expressly prohibits judicial review—in other words, the presumption dictates that such provisions must be read narrowly." *El Paso Nat. Gas Co. v. United States*, 632 F.3d

[37] *See also* 42 C.F.R. § 405.1840(a)-(b).

> 1272, 1276 (D.C. Cir. 2011). Under an appropriately narrow reading of section 1315a(d)(2), that provision does not preclude review of a challenge as to whether CMS has authority to mandate participation in section 1315a payment models.
>
> Furthermore, it is blackletter law that a preclusion of review provision does not preclude review of *ultra vires* agency action (i.e., action that is beyond the agency's authority). "Even where Congress is understood to have precluded review . . . the case law in this circuit is clear that judicial review is available when an agency acts *ultra vires*." *Aid Ass'n for Lutherans v. U.S. Postal Service*, 321 F.3d 1166, 1172-1173 (D.C. Cir. 2003); *see also Dart v. United States*, 848 F.2d 217, 221 (D.C. Cir. 1988) ("Judicial review is favored when an agency is charged with acting beyond its authority."); *Amgen v. Smith*, 357 F.3d 103, 113 (D.C. Cir. 2003 (explaining that a court "must determine whether the challenged action is of the sort shielded from review" and that "the determination of whether the court has jurisdiction is intertwined with the question of *whether the agency has authority for the challenged action*.") (emphasis added). As explained in the Providers' position paper, CMS has acted beyond its authority by interpreting section 1315a in a manner that renders it unconstitutional and superfluous with other provisions of the statute.

Finally, the Providers note that the implementing regulation at 42 C.F.R. § 510.310(e) essentially mirrors § 1315a(d)(2), and during the rulemaking process, CMS did not specify whether the regulation would preclude administrative or judicial review of challenges to CMS' authority to adopt the CJR Final Rule.

The Providers conclude that, if the Board has jurisdiction of the matters and issues raised in this appeal, then EJR is appropriate here because the Board does not have the legal authority to decide the request presented by the Providers, namely whether § 1315a of the Medicare statute authorizes CMS to mandate participation in payment models established under that section.

Board Review of the Mandatory Participation in CJR Model Issue is Precluded by Statute:

The statutory provision at 42 U.S.C. § 1315a gives the CMMI broad authority to test "innovative" payment and service delivery models. There is no explicit language as to whether CMMI can or cannot require hospitals to participate and test a model. Instead, there is explicit, clear language in the statute on the limitations on review of these models, which include: (1) the selection of models for testing; (2) the selection of organizations, sites or participants to test those models; and (3) the elements, parameters, scope and duration of such models for testing.

The Providers have raised certain challenges regarding the constitutionality of the statute and/or the regulation at issue:

> The Providers challenge the constitutionality of the statute insofar as CMS interprets it as giving the agency authority to require participation in payment models established under section 1315a. The Providers also challenge whether CMS's regulations requiring mandatory participation are consistent with the statute.[38]

However, the Providers are ultimately contesting CMMI's selection of participants as well as the scope, elements and parameters of the CJR model. The Secretary requires certain selected participants to participate, and 42 U.S.C. § 1315a(d)(2) and 42 C.F.R. § 510.310(e) are clear that there is no administrative or judicial review of these aspects of payment models developed by CMMI pursuant to its authority under § 1315a.[39] The Providers seek to attack the very aspects of the CJR model that the preclusion provisions at 42 U.S.C. § 1315a(d)(2) and 42 C.F.R. § 510.310(e) insulate from administrative and judicial review. There is no explicit language in 42 U.S.C. § 1315a(d)(2) (or in the implementing regulation at 42 C.F.R. § 510.310(e)) to limit participation to volunteers. Moreover, the Board notes that the Secretary makes clear in the preamble discussion in the CJR 2015 Final Rule that the § 1315a(d)(2) preclusion provisions apply to the Secretary's decision to require selected participants to participate in the CJR model as shown in the following excerpt that responds to comments questioning the Secretary's "legal authority to require participation in the model"[40]:

> We note that while CJR will be a model, and not a permanent feature of the Medicare program, the model will test different methods for delivering and paying for services covered under the Medicare program, which the Secretary has clear legal authority to regulate. The proposed rule went into great detail about the provisions of the proposed CJR model, enabling the public to fully understand how the proposed model was designed and could apply to affected providers. We acknowledge section 1115A(d)(2) of the Act, *which states that there shall be no administrative or judicial review of, among other things, "**the selection of organizations, sites, or participants to test . . . models selected**," as well as the commenter's concern that this provision would preclude a participant hospital from appealing its selection as a participant in the CJR model*. However, it is precisely because the model will

[38] Providers' Response to Board RFI at 3 (Jan. 31, 2022).
[39] The Board notes that the Providers *ultra vires* arguments in this case are beyond the scope of Board review and that there is case law addressing when the *ultra vires* is applicable. *See, e.g.*, *Scranton Quincy Hosp. Co. v. Azar*, 514 F. Supp. 3d 249 (D.D.C. 2021); *Ascension Borgess Hosp v. Becerra*, 557 F. Supp. 3d 122 (D.D.C. 2021); *Florida Health Sciences Ctr., Inc. v. Secretary of Health & Human Servs.*, 830 F.3d 515 (D.C. Cir. 2016); *DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503 (D.C. Cir. 2019); *Mercy Hosp., Inc. v. Aar*, 891 F.3d 1062 (D.C. Cir. 2018); *Knapp Med. Ctr. v. Hargan*, 875 F.3d 1125 (D.C. Cir. 2017).
[40] 80 Fed. Reg. at 73277.

> impose new requirements upon participant hospitals that we undertook notice and comment rulemaking to implement it.[41]

The Providers argue that CMS' "extremely broad" interpretation of the authority granted to it under §1315a violates the non-delegation doctrine which prohibits unconstitutional delegations of Congressional authority. However, the "extremely broad interpretation" that the Providers are referring to is the authority to require participation in the models that CMMI implements under the authority of § 1315a. The Congressional intent of the statutory preclusion of review of this aspect of the CJR model is clear; there is no ambiguity in the plain language of the statute and the Secretary's position that it applies to the required participation of selected participants.

The Board recognizes that the Provider suggest that the § 1315a(d)(2) preclusion provisions do not apply because mandatory participation in the CJR model would conflict with 42 U.S.C. § 1395cc-4, which outlines a National Pilot Program on Payment Bundling that was to be established by the Secretary for integrated care during an episode of care provided to an applicable beneficiary around a hospitalization in order to improve the coordination, quality, and efficiency of health care services under this title. The pilot program was required to be established no later than January 1, 2013. Participation was voluntary in that "[a]n entity comprised of providers of services and suppliers, including a hospital, a physician group, a skilled nursing facility, and a home health agency, who are otherwise participating under this title, may submit an application to the Secretary to provide applicable services to applicable individuals under this section." This program was limited to patients with an "applicable condition" which is defined as one (1) or more of ten (10) conditions selected by the Secretary.

However, the Board finds that the payment models implemented by CMMI, and in particular the CJR model at issue here, are different from the pilot program under § 1395cc-4, thereby not having an effect on the working of the pilot program under § 1395cc-4, or rendering it superfluous, as the Providers argue. The pilot program under § 1395cc-4 was one *specific* pilot program, whereas §1315a provides CMMI broad authority to develop models of payment programs that are broad in scope and throughout the Medicare program, and not just limited to Part A providers providing care surrounding the hospitalization of a beneficiary with certain listed conditions. Unlike § 1395cc-4, there is no explicit language in §1315a to limit participation in payment models to volunteers. Rather, the language in §1315a provides CMMI with broad authority to develop their payment models so long as the goals in that statutory provision are being carried out, as evident by the limitations on review provisions. Moreover, while the CJR payment model is one of the *first* to require selected participants to test the model, the Board notes that the Secretary adopted and implemented other models under CMMI's authority under § 1315a that similarly requires selected participants to participate.[42]

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[41] *Id*. at 73278 (emphasis added). *See also* the final rules in *infra* note 42 discussing other models established pursuant to §1315a that require participation by selected participants because these final rules include similar discussion by the Secretary of his authority to require participation.

[42] *See* 80 Fed. Reg. 68624 (Nov. 5, 2015) (implementing the HHVBP model that home health agencies in selected states were required to participate beginning in January 2016); 82 Fed. Reg. 180 (Jan. 3, 2017) (implementing the cardiac rehabilitation incentive payment model that acute care hospitals in certain selected geographic areas were required to participate beginning July 1, 2017).

Finally, the Board notes that 42 C.F.R. § 510.310 specifically explains the appeal process for the CJR model and this process does *not* grant the Board jurisdiction to hear the delineated challenges to the CJR model (much less recognize or acknowledge *any* appeal rights to the Board).[43] This is significant because subsection (d) of § 510.310 is where the Secretary codified into his regulations the statutory preclusion provisions at issue. Indeed, this limited appeal process reinforces the Board's finding that administrative review of the Providers' appeal is precluded by statute and regulation. For these reasons, the Board is not the correct forum for review of the issues raised in the Providers' appeal. Accordingly, it is clear that, pursuant to 42 U.S.C. § 1315a(d)(2) and 42 C.F.R. § 510.310(e), the Board lacks substantive jurisdiction and the appeal must be dismissed consistent with 42 C.F.R. §§ 405.1840(a)(4), (b), (c)(2).

Conclusion:

The Providers challenge to the constitutionality of the CJR statute and implementing regulations ultimately contest CMMI's selection of participants as well as the scope, elements and parameters of the CJR model. The Secretary requires certain selected participants to participate, and 42 U.S.C. § 1315a(d)(2) and 42 C.F.R. § 510.310(e) are clear that there is no administrative or judicial review of these aspects of payment models developed by CMMI pursuant to its authority under § 1315a. The Providers seek to attack the very aspects of the CJR model that the preclusion provision insulates from review. Accordingly, the Board finds that it lacks substantive jurisdiction and dismisses the appeal consistent with 42 C.F.R. §§ 405.1840(a)(4), (b), (c)(2).[44]

As there are no issues remaining in this appeal, the Board hereby 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.[45]

Board Members Participating:

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For the Board:

10/26/2022

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.

[43] Similarly, the preamble discussion of the appeals process in the CJR 2015 Final Rule does not recognize or acknowledge any appeal rights to the Board. *See* 80 Fed. Reg. at 73408-12. Similarly, the Secretary did not revise the appeals process when it revisited it as part of the 2017 final rule for a cardiac rehabilitative incentive payment model discussed at *supra* note 42.
[44] As a result of this finding, review of potential EJR would not be appropriate per 42 C.F.R. § 405.1842(b)(1), (f)(2)(i).
[45] *See also* 42 C.F.R. § 405.1840(c)(3).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Donald Anderson
Providence Health & Services
2001 Lind Ave SW
Renton, WA 98057

RE: ***Motion for Reinstatement***
Providence Holy Cross Medical Center (Prov. No. 05-0278)
FYE 12/31/2014
Case No. 18-1552

Dear Mr. Anderson,

The Provider Reimbursement Review Board ("Board") has reviewed the letter requesting reinstatement ("Motion for Reinstatement") submitted for Providence Holy Cross Medical Center ("Provider") on September 16, 2022. The decision of the Board is set forth below.

Pertinent Facts:

On August 3, 2018, the Board received the Provider's individual appeal request for fiscal year ending December 31, 2014. On September 13, 2019, the Board received a Notice of Appeal Withdrawal from the Provider subject to Board Rule 46. The letter reads:

> The Medicare Administrative Contractor, Noridian Healthcare Solutions and Provider are agreeable to administratively resolve the issues in the individual appeal, i.e. Title XIX eligible patient days. If the matter cannot be resolved through the reopening process, the Provider will reinstate the appeal *per the terms of PRRB Rule 46*.[1]

A Board letter of September 19, 2019 acknowledged the withdrawal and closed the appeal.[2]

Subsequently, on Friday, September 16, 2022, the Provider submitted a motion asking the Board to reinstate the appeal *pursuant to Board Rule 47*, specifically the Medicaid Eligible Days issue in the appeal, because "the Medicare contractor agreed to reopen/revise the cost report for DSH – Medicaid Eligible Days but failed to reopen the cost report and issue a new final determination for that issue as agreed."[3] In accordance with Board Rules 47.1 and 47.2.2, attached was a copy

[1] Notice of Appeal Withdrawal (Sept. 13, 2019) (emphasis added).
[2] The PRRB Proceedings in OH CDMS for this case describe this action as "Acknowledgment of Case Withdrawal."
[3] Holy Cross Reinstatement Request (Sept. 16, 2022).

of the Provider's reopening request[4] and correspondence from the MAC agreeing to reopen the final determination for that issue.[5]

Statutory and Regulatory Background

A Medicare Contractor may reopen a cost report within three years of the date of the NPR.[6] A provider may withdraw an issue in an appeal for which the Medicare Contractor has agreed to reopen the final determination (*i.e.*, the cost report).[7] Following such a withdrawal, the provider may file a motion for reinstatement "*within three years* ***of the Board's receipt of the provider's withdrawal of the issue(s)*** (*see* 42 C.F.R. § 405.1885 addressing reopening of Board decisions).[8] The motion must be in writing and include copies of the provider's reopening request and the Medicare Contractor's agreement to reopen the final determination.[9]

Board's Decision:

As set forth below, the Board denies the Provider's Motion for Reinstatement.

In its September 13, 2019 withdrawal, the Provider recognized that any subsequent reinstatement request would have to be done in compliance with Board Rules but incorrectly stated that it would be governed by Board Rule 46. Board Rule 46 (Aug. 2018) addresses withdrawals and states, in pertinent part:

> A provider's request to withdraw an issue(s) or case must be in writing. It is the provider's responsibility to withdraw: . . . (3) an issue(s) for which the Medicare contractor has agreed to reopen the final determination for that issue(s) and attach a copy of the correspondence from the Medicare contractor where the Medicare contractor agreed to that reopening; (4) all issues in a case where the provider intends to pursue reopening simultaneously with the appeal request (see Rule 47.2.3); . . . .
>
> When a provider notifies the Board that it is withdrawing an issue(s), the provider's notification must: (1) describe the specific issue(s) being withdrawn; (2) address whether the withdrawal is conditioned/dependent on the Medicare contractor's action through an administrative resolution or reopening; and (3) confirm whether

[4] Attachment A to Reinstatement Request, the Provider's September 3, 2019 letter to the MAC requesting reopening.
[5] Attachment B to Reinstatement Request, the MAC's November 4, 2019 Notice of Reopening of Cost Report on the Medicare DSH Medicaid-Eligible Days Issue for FY 2014.
[6] 42 C.F.R. § 405.1885.
[7] Board Rule 46.
[8] Board Rule 47.1.
[9] Board Rule 47.2.2.

> there are any other issues remaining in the case and, if so, provide the status on each remaining issue. *Note that the Board will not issue a decision to **acknowledge** the withdrawal of an issue(s) if the withdrawal does not result in the closure of the case*.[10]

The Provider's request for reinstatement is governed by Board Rule 47 (Aug. 2018) which addresses reinstatement and states in pertinent part:

> **Rule 47 Reinstatement**
>
> **47.1 Motion for Reinstatement**
>
> A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, *if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s)* (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions). The request for reinstatement is a motion and must be in writing setting out the reasons for reinstatement (see Rule 44 governing motions). The Board will not reinstate an issue(s)/case if the provider was at fault. If an issue(s)/case was remanded pursuant to a CMS ruling (e.g., CMS Ruling 1498-R), the provider must address whether the CMS ruling permits reinstatement of such issue(s)/case. If the Board reinstates an issue(s) or case, the provider will have the same rights (no greater and no less) that it had in its initial appeal. *These requirements also apply to Rule 47.2 below*.
>
> **47.2 Reinstatement Requests Subsequent to Withdrawal**
>
> ****
>
> **47.2.2 Medicare Contractor Agreement to Reopen**
>
> Upon written motion, the Board will also grant reinstatement of an issue(s)/case if a provider requested to withdraw an issue(s) from its case because the Medicare contractor agreed to reopen/revise the cost report for that issue(s) but failed to reopen the cost report and issue a new final determination (e.g., Revised NPR) for that issue(s) as agreed. In its motion for reinstatement, the provider must attach a copy of its reopening request and the correspondence from the Medicare contractor where the Medicare contractor agreed to reopen the final determination for that issue(s).

[10] (Emphasis added.)

The Provider requested the Medicare Contractor reopen the cost report to address the count of the Medicaid-eligible days and the related DSH adjustment. The Medicare Contractor agreed to reopen the cost report for those days/issue. Consistent with that agreement and Board Rule 46, the Provider filed its request for withdrawal of the case on Tuesday, September 13, 2019. As the Medicare Contractor failed to issue an RNPR as agreed, the Provider filed a request for reinstatement on Friday, September 16, 2022.

Although the Medicare Contractor did not issue a RNPR as agreed, the Provider failed to file its request for reinstatement *within the three-year time frame to file for reinstatement* as required by Board Rule 47.1.[11] As specified in Board Rule 47.1, "A provider may request reinstatement of an issue(s) or case within three years from the date of the Board's decision to dismiss the issue(s)/case or, *if no dismissal was issued, within three years of the Board's receipt of the provider's withdrawal of the issue(s)* (see 42 C.F.R. § 405.1885 addressing reopening of Board decisions)."[12] The Board measures 3 years from the date of its receipt of a withdrawal request (whether for an issue or case) because the Board considers such requests as self-effectuating upon filing.

Here, the Board did not issue a decision to dismiss and, as such, the three-year period is governed by "the Board's receipt of the provider's withdrawal." Accordingly, since the Provider filed its withdrawal on Friday, September 13, 2019, its request for reinstatement could be filed no later than Tuesday, September 13, 2022 (*i.e.*, 3 years from September 13, 2019). However, the Provider filed its reinstatement request 3 days late on Friday, September 16, 2022. As the Provider did not file its request for reinstatement within the three-year timeframe specified in Board Rule 47.1, the Board denies the Motion for Reinstatement and Case No. 18-1552 remains closed.[13]

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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Ratina Kelly, CPA

For the Board:

10/26/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
John Bloom, Noridian Healthcare Solutions (J-F)

[11] Board Rule 47.1
[12] (Emphasis added.)
[13] The fact that the Provider appears to meet the other prerequisites in Board Rule 47.2.2 for reinstatement does not change the fact that the reinstatement request was not timely filed (*i.e.*, within 3 years of the Board's receipt of the September 13, 2019 withdrawal) and, as a result, was fatally flawed.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Jurisdictional Decision on Participant #2* – RNPR Medicaid Days Adjustment**
Participant #2, Mercy Hospital (Prov. No. 10-0061, FYE 12/31/2004)
Case No. 19-1888GC
Trinity Health CY 2004 (pre-10/1/2004) DSH Medicare + Choice Days CIRP Group

Dear Messrs. Coyle and Snyder:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group under Case No. 19-1888GC. The Board's decision is set forth below regarding Participant #2, Mercy Hospital (Provider No. 10-0061, FYE 12/31/2004) appealing a revised notice of program reimbursement ("revised NPR" or "RNPR") dated October 13, 2008.

Background

The Providers in Case No. 07-1675GC, *CHE 2004 DSH Medicare+Choice Days Group*, requested that the Board bifurcate the appeal based on discharges occurring before October 1, 2004, and discharges occurring on or after that date.[1] The reasoning behind that bifurcation request was that the cost reporting periods involved in the group ". . . overlap the October 1, 2004 effective date of CMS's policy change purporting to require the inclusion of part C days in the Medicare part A/SSI fraction and the exclusion of those days from the Medicaid fraction."[2] Because the policy cannot be retroactively applied, the Providers requested that the discharge days must be treated differently.[3]

On May 14, 2019, the Board granted the request, and bifurcated the pre-October 1, 2004, discharges issue from the discharges on or after October 1, 2004 issue.[4] Specifically, the Board created Case No. 19-1888GC for the *pre*-October 1, 2004 Part C Discharges issue, and ordered that the Part C Discharges *on or after* October 1, 2004 would remain in Case No. 07-1675GC.[5]

Mercy Hospital (Prov. No. 10-0061, 12/31/2004) as Participant ##1 & 2

Mercy Hospital has appealed both an original and revised NPR in this group. As a result, the Schedule of Providers for this case lists Mercy Hospital's appeal of its original NPR as Participant

[1] Request for Bifurcation, at 1 (May 1, 2019), Case No. 07-1675GC.
[2] *Id*.
[3] *Id*.
[4] Board's Grant of Request for Bifurcation in Case No. 07-1675GC (May 14, 2019).
[5] *Id*.

#1 and its appeal of the revised NPR as Participant #2. The Provider's revised NPR was issued on October 13, 2008, and included an adjustment to Medicaid eligible days included in the DSH Medicaid fraction at Audit Adjustment No. 8.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more ($50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885, which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are ***specifically*** *revised* in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) *Any matter that is not* ***specifically*** *revised* (including any matter that was reopened but not revised) *may* ***not*** *be considered* in any appeal of the revised determination or decision.[6]

42 C.F.R. § 405.1835(a) explains a provider's right to appeal to the Board and specifically references § 405.1889:

[6] (Emphasis added.)

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[7]

As described below, the Board finds that it does not have jurisdiction over Mercy Hospital's appeal of the revised NPR, because Part C days were not *specifically* adjusted. Indeed, no adjustment was even made to the SSI fraction where Part C days are counted per the FY 2005 IPPS final rule. Here, the Provider's audit adjustment report shows that there was only an adjustment to Medicaid eligible days included in the Medicaid fraction (neither to Part C days nor the SSI fraction were specifically adjusted) and, as a result, the Board lacks jurisdiction over the Part C days *as appealed from the revised NPR* pursuant to 42 C.F.R § 405.1889(b). In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[8]

In conclusion, the Board hereby dismisses the revised NPR appeal of Participant #2,Mercy Hospital (Prov. No. 10-0061, FYE 12/31/2004) from Case No. 19-1888GC. The Board notes that, notwithstanding, this Provider remains pending in the group as Participant #1 based on its appeal of its original NPR. The Board will remand the remaining participants under separate cover pursuant to CMS Ruling 1739-R. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

Board Members Participating:

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

For the Board:

10/26/2022

X Clayton J. Nix

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

[7] (Emphasis added.)
[8] *See St. Mary's of Mich. v. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*, 464 F. Sup. 3d 1 (D.D.C. 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *St. Dominic-Jackson Mem'l Hosp. v. Sebelius*, 2014 WL 8515280 (S.D. Miss. 2014). *See also HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994); *French Hosp. Med. Ctr. v. Shalala*, 89 F.3d 1411 (9th Cir. 1996); *Baptist Mem'l Hosp. v. Sebelius*, 768 F. Supp. 2d 295 (D.D.C. 2011).

cc: Wilson Leong, Federal Specialized Services
Attachment A – Schedule of Providers

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Tina Kirkman
UNC Rockingham Health Center
117 East Kings Highway
Eden, NC 27288-5299

RE: ***Notice of Dismissal***
Morehead Memorial Hospital (Prov. No. 34-0060)
FYE: 09/30/2009
Case Number: 14-2669

Dear Ms. Kirkman:

The Provider Reimbursement Review Board ("Board" or "PRRB") reviewed the record of the above captioned appeal, and for the reasons explained below, the Board hereby dismisses the appeal with prejudice.

Background

On February 26, 2014, the Board received Morehead Memorial Hospital's ("Provider") individual appeal request appealing their August 30, 2013 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2009. In a letter dated October 3, 2014, the Provider notified the Board that its new Provider Representative was Tina Kirkman of Morehead Memorial Hospital.

On September 3, 2021, the Board issued a Notice of Hearing to the parties with several due dates for position papers, witness lists, and position paper copies. The hearing date was scheduled for May 16, 2022. The Provider did not file a position paper or witness list in response to this Notice of Hearing, and did not appear for the hearing date.

On June 16, 2022, the Board rescheduled the appeal and sent a second Notice of Hearing to the parties with several due dates for position papers, witness lists, and position paper copies. The rescheduled hearing date was set for October 18, 2022. The Provider did not file a position paper or witness list in response to this Notice of Hearing, and did not appear for the hearing date.

Board staff has attempted to reach Tina Kirkman, Provider Representative, at her e-mail address and phone number, with no success.

Board Decision

Pursuant to 42 C.F.R. § 405.1868, 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 Social Security Act and 42 C.F.R, Part 405,

Subpart R. Additionally, if a provider fails to meet a filing deadline or other Board requirement (established by Board rule or Board order), then the Board may dismiss the appeal with prejudice.

PRRB Rule 5.2 states the responsibilities of a Provider Representative as

> 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/ReviewBoards/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;
> - 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.

PRRB Rule 41.2 states

> The Board may dismiss a case or an issue on its own motion:
>
> - if it has a reasonable basis to believe that the issues have been fully settled or abandoned;
> - 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.

The Provider Representative has failed to provide current contact information to the Board, has failed to meet the deadlines outlined in the Notices of Hearing, and has failed to timely correspond with the Board regarding the status of this appeal. For these reasons it is evident the Provider has abandoned pursuit of this appeal, and the Board hereby dismisses the appeal with prejudice.

Board Members:

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

For the Board:

10/27/2022

X Kevin D. Smith, CPA

Kevin D. Smith, CPA
PRRB Member
Signed by: Kevin D. Smith -A

cc: Wilson C. Leong, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.

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

Mr. Wayne Thompson, CFO
Northlake Behavioral Health System
23515 HWY 190
Mandeville, LA 70435

RE: Northlake Behavioral Health System
Provider No.: 19-4007
PRRB Case No.: 22-1499

Dear Mr. Thompson:

BACKGROUND:

The above-captioned appeal was filed with the Provider Reimbursement Review Board (Board) using the Office of Hearings Case and Document Management System (OH CDMS) on September 27, 2022 and was assigned case number 22-1499.

FACTS:

The appeal request indicated that the case is based on an "Other" final determination. Upon review of the appeal request, it is noted that the Provider failed to submit a copy of a final determination (i.e. Notice of Program Reimbursement ("NPR"); Revised NPR; Federal Register, etc.) in dispute. The document filed as the Provider's final determination was an explanation of why it was filing the appeal.

Further review also indicates that there is a discrepancy regarding the fiscal year end ("FYE") in dispute. On the General Information Form, located within the Issue field, the Provider indicated that the cost report periods affected were 12/31/2016 and 12/31/2021. However, in the Determination Field, the Provider has input the FYEs affected as 11/1/2016 to 12/31/2021. If the Provider intended to appeal multiple FYEs, then it is required to file a separate appeal request for each FYE.

It is also noted that the Provider lists the final determination date as December 31, 2021, but filed the appeal on September 27, 2022, on day 270. Appeals are due to the Board with 180 days of the final determination issuance.

RULES AND REGULATIONS:

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

Board Rule 4. 1 General Requirements states:

See 42 C.F.R §§ 405.1835 – 405.1840.

The Board will dismiss appeals that fail to meet the timely filing requirements and/or jurisdictional requirements. A jurisdictional challenge (See Rule 44.4) may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The parties cannot waive jurisdictional requirements.

Board Rule 4.3.1 Contractor/CMS/Secretary Final Determination outlines a final determination as:

- Notices of Program Reimbursement;
- Revised Notices of Program Reimbursement;
- Exception Determinations,
- Quality Reporting Program Payment Reduction Determinations; and
- Other determinations issued by CMS or its contractors with regard to the amount of total reimbursement due the provider.

The date of receipt of a contractor/CMS/Secretary final determination is presumed to be five (5) days after the date of issuance. This presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date. See 42 C.F.R. § 405.1801(a)(1)(iii).

The appeal period begins on the date of receipt of the contractor final determination as defined above and ends 180 days from that date.

Board Rule 6.1.1 Requesting and Supporting Documentation states:

To file an individual appeal, the case representative must log onto OH CDMS and follow the prompts. Reference Rules 7 and 9 as well as Model Form A – Individual Appeal Request (Appendix A) for guidance on all required OH CDMS data fields and supporting documentation. The Board will dismiss appeal requests that do not meet the minimum filing requirements as identified in 42 C.F.R. § 405.1835(b) or (d), as relevant.

Board Rule 7.1.1 General Requirements states:

Identify the appealed period. This is typically the fiscal year end ("FYE") covered by the cost report but may include an alternative period such as a calendar year ending 12/31, a federal fiscal year ending 9/30, or another period for which you must identify the beginning and ending dates. If the period is something other than a traditional cost report FYE, you must identify the cost reporting periods affected by the determination. Example: Provider has a 6/30 FYE and is appealing a Federal Register notice applicable to 9/30/18. The impacted cost reporting periods would be FYE 6/30/18 (based on the portion of the FFY from 10/1/17 through 6/30/18) and FYE 6/30/19 (based on the remainder of the FFY from 7/1/18 through 9/30/18). Include a copy of the final determination, such as the NPR, revised NPR, exception determination letter, Federal Register notice, or quality reporting payment reduction decision. Note that preliminary determinations are not appealable. (See Rule 7.5 for appeals based on the lack of a timely issued determination.) Identify the date the final determination was issued. Ensure the appeal is filed timely based on the appeal period in Rule 4.3.

Pursuant to 42 C.F.R. § 405.1868(a)-(b):

(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.

CONCLUSION:

Upon review of the subject appeal request, the Board has concluded that the Provider failed to submit a final determination with the appeal request. As noted above, the submittal of the final determination, on which the appeal is based, is required by the Board when filing an appeal and failure to do so will result in dismissal. Without the final determination the Board is also unable to ascertain if the appeal is filed timely.

From the review of the documentation that was provided, it is unclear on what basis the Provider is appealing the issue before the Board. The Provider indicated it is appealing the disallowance of interest expense but failed to file a final determination or issue statement with the appeal request, as required.

Accordingly, pursuant to its authority under 42 C.F.R. § 405.1868, the Board hereby dismisses this case for failure to file the regulatory required documents with the appeal request, and failure to document it met the timely filing requirements. The case is therefore removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

FOR THE BOARD:

10/28/2022

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

October 31, 2022

Doug Lemieux
Corporate Reimbursement Director
Centura Health
9100 East Mineral Circle
Suite 300
Centennial, CO 80112

Bill Tisdale
Director, JH Provider Audit & Reimbursement
Novitas Solutions, Inc. (J-H)
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: Dismissal for Failure to Respond to CIRP Group Status Request
Centura Health FY 2012 Documentation and Coding Adjustment CIRP Group
PRRB Case Number: 14-3930GC

Dear Mr. Lemieux and Mr. Tisdale:

In a notification issued on May 3, 2022, the Provider Reimbursement Review Board (the "Board") advised the Parties that there had been no Providers added or transferred into the group in over 8 years (indeed the last filing made by the group representative was in 2014 in response to a Board request for information). Consequently, the Board requested that, no later than June 3, 2022, the Representative advise the Board whether the group is fully formed based on the existing participants (in this case for which there is only one). In the alternative, if the group is not complete, the Representative was directed to file a status report identifying any providers for which it was still awaiting the issuance of a final determination. The notification also advised that the deadline was exempt from the Board Alert 19 suspension of Board-set deadlines and that failure to submit a timely response would result in dismissal of the case. Pursuant to 42 C.F.R. § 405.1868(b), "[i]f a providers 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.". . . Because the Representative failed to respond to the Board's May 3, 2022 notification by the designated June 3, 2022 deadline and has apparently abandoned the case (as demonstrated by the failure to respond to the Board inquiry and the multiple years of inactivity in this case), the Board hereby dismisses Case No. 14-3930GC and removes it from the Board's docket pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b).

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

FOR THE BOARD:

Clayton J. Nix, Esq.
Chair

cc: Wilson C. Leong, Federal Specialized Services