DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Dismissal of Appeal Due to Late Filing of Initial Request for Hearing***
Ronald Reagan UCLA Medical Center (Prov. No. 05-0262)
FYE 6/30/2017
Case No. 19-1971

Dear Mr. Dreyfus and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal in response to the Medicare Contractor's challenge relate to the timely filing of the appeal. The pertinent facts of the case and the Board's decision are set forth below.

Background

On May 29, 2019, the Provider submitted a *Request to Form Individual Appeal* ("RFH") establishing Case No. 19-1971. This appeal was filed pursuant to the Provider's right to a hearing based on an untimely contractor determination and included a single issue, Understated IPPS Standardized Amount.[1] The Board issued the Acknowledgement letter and set Preliminary Paper deadlines for the Provider on June 5, 2019.

On July 7, 2020, Noridian Healthcare Solutions (the "MAC") submitted two challenges, (1) stating that the provider's appeal was late from the acceptance of the cost report and subsequent failure to issue a final determination, and (2) a substantive cost report claim challenge, stating that the provider failed to make a s substantive claim for the issue in dispute.[2]

MAC's Challenges

In the first challenge, the MAC contends that this Provider's appeal, which is based on the Provider's right to a hearing based on an untimely contractor determination, is untimely.[3]

[1] Provider's Request for Hearing (May 29, 2019).
[2] MAC's Jurisdictional Challenge (Jul. 7, 2020); MAC's Substantive Claim Letter (Jul. 7, 2020).
[3] MAC's Jurisdictional Challenge (Jul. 7, 2020).

The MAC notes that the Provider's cost report for this cost reporting period was received by the MAC *on November 29, 2017*.[4] The Provider filed an Appeal Request with the Board on May 29, 2019. The Board acknowledged the request on June 5, 2019. The appeal request was filed pursuant to the Provider's right to a hearing based on an untimely contractor determination. 42 C.F.R. § 405.1835(c) provides that a provider appeal pursuant to an untimely contractor determination must be received by the Board no later than 180 days *after the expiration of the twelve-month period following the MAC's receipt of the latest accepted cost report*. In this case, the 180-day deadline fell on May 28, 2019, but the Provider did not submit its Appeal Request to the Board until May 29, 2019. Therefore, the MAC contends that the Provider's appeal request is untimely.[5]

In its second challenge, the MAC alleges that the Provider's filed cost report does not include an appropriate claim for the appealed item in dispute – i.e., Understated IPPS Standardized Amount.[6]

As part of the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28206-28217), the Secretary proposed revisions to the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary proposed that payment for the item will not be included in the Notice of Program Reimbursement (NPR) issued by the Medicare Administrative Contractor (MAC) or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. 405.1801(a)) in an administrative appeal filed by the provider. The proposed changes were finalized as part of the CY 2016 OPPS final rule (80 FR 70551-70580). The finalized regulations are effective with cost reporting periods beginning on or after January 1, 2016.[7]

The MAC argues, according to 42 C.F.R. § 405.1873, in order to receive reimbursement for a specific item, the Provider must include in its cost report an appropriate claim for the specific item as prescribed in 42 C.F.R. § 413.24(j).[8]

According to its appeal request, the Provider is appealing Issue 1 – Understated IPPS Standardized Amounts.[9] Specifically, the Provider contends that:

> The original standardized amount that was established in 1983 is understated because Health & Human Services (HHS) erroneously treated transfers of patients from one hospital to another as

[4] *Id*. at Exhibit C-2.
[5] MAC's Jurisdictional Challenge at 1.
[6] MAC's Substantive Claim Letter at 2.
[7] *Id*.
[8] *Id*. at 3.
[9] The MAC notes that, in its Appeal Request, the Provider identified the Amount in Controversy as $882,480 (*see* Exhibit C-1 at 3), and later states the Estimated Impact as $594,550 (*see* Exhibit C-1 at p. 5). The Provider's attached Standardized Amount Calculation lists the Estimated Impact as $882,480.

> discharges. This overstated the number of discharges used to compute the average allowable operating costs per case and, consequently, understated the standardized amount. This original historical error has caused underpayments each and every subsequent fiscal year.
>
> The error in the original standardized amount calculation has been perpetuated because the standardized amount has been updated annually for inflation but not recalculated each year. All of the inflation updates are compounded into the current standardized amount for each facility. The Provider seeks a correction to the standardized amount calculation in the base year (1983) that would allow for correction of the Secretary's error in the current appealed years.[10]

Based on the procedures at 42 C.F.R. § 413.24(j)(3), the MAC contends that there is not an appropriate cost report claim for this specific item included in the Provider's cost report. The Provider did not claim an amount it thought it was owed on its cost report, purportedly stemming from the "reduced" IPPS DRG amounts, even though it identified an amount related to the purported underpayment. Thus, the Provider has not claimed reimbursement for Understated IPPS Standardized Amounts in the Provider's cost report in accordance with Medicare policy.[11]

The MAC notes that the Provider filed its Medicare cost report identifying $8,878,327 of Part A Protested Amounts. A review of the Provider's supporting workpapers show that the Provider did not establish a self-disallowed item for the Standardized Amount Issue. Furthermore, none of the exceptions at subsections (3)(i) through (3)(iii) apply. Together, with the above, it is clearly shown that the Provider did not include in its June 30, 2017 cost report an appropriate claim for the specific item under appeal as prescribed in 42 C.F.R. § 413.24(j).[12]

The MAC requests that the Board find that there is not an appropriate cost report claim for a specific item in dispute, and that the item is not reimbursable, regardless of whether the Board further determines in a final hearing decision that the other substantive reimbursement requirements for the specific item are or are not satisfied.[13]

Provider's Response

The Provider had 30 days to respond under Board Rule 44. However, to date, the Provider has not filed a response to the MAC's challenges. The Board notes that, pursuant to Board Rule 44.4.3, "Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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[10] MAC's Substantive Claim Letter, at 5.
[11] *Id*.
[12] *Id*.
[13] *Id*. at 6.

Board's Analysis and Decision

Initial Filing of Appeal

Pursuant to 42 C.F.R. § 405.1868(b) and Board Rule 4.1, if a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may dismiss the appeal with prejudice. Pursuant to 42 C.F.R. § 405.1801(a) and Board Rule 3, the date of filing is the date of receipt by the Board, or the date of delivery by a nationally-recognized next-day courier.

As noted above, the appeal was filed pursuant to the Provider's right to a hearing based on an untimely contractor determination. 42 C.F.R. § 405.1835(c) provides that a provider appeal pursuant to an untimely contractor determination must be received by the Board no later than 180 days after the expiration of the twelve-month period following the MAC's receipt of the latest accepted cost report:

> (c) *Right to hearing based on untimely contractor determination*. Notwithstanding the provisions of paragraph (a) of this section, a provider (but no other individual, entity, or party) has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if -
>
> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) **within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter)**. The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, **the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination** (as determined in accordance with paragraph (c)(1) of this section); and
>
> (3) The amount in controversy (as determined in accordance with § 405.1839) is $10,000 or more.[14]

[14] 42 C.F.R. § 405.1835(c) (bold emphasis added).

In this case, the MAC presented evidence at Exhibit C-2 establishing that the MAC received the cost report at issue on November 29, 2017.[15] However, the MAC failed to issue the NPR within 12 months and the Provider had 180 day after the expiration of that 12 months to file an appeal. Accordingly, the deadline fell on Tuesday, May 28, 2019 (12 months plus 180 days from November 29, 2017), but the Provider did not submit its Appeal Request to the Board until May 29, 2019, 181 days after the 12-month period for issuing an NPR had expired. In concert with Rule 4.3, Board Rule 4.1 states that appeals that fail to meet the timely filing requirements or jurisdictional requirements will be dismissed.[16] Accordingly, the Board finds that the Provider's appeal request is untimely.[17]

Accordingly, as the Board received UCLA's RFH after the applicable 180-day time limit, the Board dismisses the appeal as it was untimely pursuant to 42 C.F.R. § 405.1835(c) (2015) and closes the case. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Substantive Claim Challenge

As the appeal was not filed timely and is being dismissed for that reason, the Board did not reach or analyze the substantive claim challenge made by the MAC.

Board Members Participating:

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

For the Board:

11/10/2021

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[15] The Board notes that the Provider has not challenged the date of receipt or, for that matter, responded to the MAC's jurisdictional challenge. The Board notes that, pursuant to Board Rule 44.4.3, "Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."
[16] *Id.* at Rule 4.1. The Board recognizes that a provider may invoke the good cause exception under 42 C.F.R. § 405.1836 but, here, the Provider has not done so and, as a result, § 405.1836 is not applicable.
[17] MAC's Jurisdictional Challenge at 1.

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Nan Chi
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RE: ***Jurisdictional Decision***
Houston Methodist Hospital (Prov. No. 45-0358)
FYE 12/31/2009
Case No. 15-3458

Dear Ms. Chi and Mr. Tisdale,

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

Background

Houston Methodist Hospital ("Provider"), is appealing the amount of Medicare Reimbursement as determined by the Medicare contractor. The Provider appealed the following nine (9) issues[1]:

1) SSI Percentage, Provider Specific
2) SSI Percentage, Provider Specific
3) SSI Percentage, Systemic Errors
4) DSH, Medicaid Eligible Days
5) DSH, Medicare Managed Care Part C Days
6) DSH, Dual Eligible Exhausted Part A Days
7) Capital IME & DSH
8) Revenue Code 810 Charges
9) 2006 Inpatient Agency Bad Debt

After all withdrawals and transfers, only issues 8 and 9 remain in the subject appeal. The Medicare Contractor filed a jurisdictional challenge over issue 9 on March 9, 2021. The Provider submitted its response on April 9, 2021.

[1] Model Form A – Individual Appeal Request (September 28, 2015), Tab 3.

Medicare Contractor's Position

Issue No. 9 2006 Inpatient Agency Bad Debt

The Medicare Contractor asserts that it did not render an adverse determination over the disputed bad debts. The Provider has not properly preserved its right to claim dissatisfaction for the disputed bad debts as a self-disallowed item in accordance with 42 C.F.R. § 405.1835(a)(1)(ii). Furthermore, in light of the provisions of CMS Ruling 1727-R, the Medicare Contractor contends that there was no legal impediment preventing the Provider from claiming the disputed bad debts. The Medicare Contractor contends that the Provider is seeking reimbursement of bad debts that were not claimed on its FYE 2009 as-filed cost report.

The Provider cites Audit Adjustment No. 59 as the source of its dissatisfaction. Audit Adjustment No. 59 was made to "... REMOVE[INPATIENT] HIGH STRATA BAD DEBTS DUE TO THE LACK OF DOCUMENTATION." However, the Medicare Contractor notes that this Adjustment did not render a determination over (or otherwise pertain to) the disputed bad debts. Rather, this Adjustment adjusts certain other bad debts that were claimed on the Providers FYE 200**9** as-filed cost report. Audit Adjustment No. 59 disallowed $106,111 of FYE 200**9** bad debts. This adjustment involves one account for services rendered in 2008. Similarly, the Medicare Contractor notes that, while the as-filed FY 2009 cost report did included protested amounts totaling in the aggregate $337,370, none of those protested items pertained to bad debts; rather they all pertained to DSH.

The Medicare Contractor issued the Provider's 200**6** NPR on December 4, 2010 adjusting off the disputed bad debts. Specifically, the Medicare Contractor states it reviewed ten accounts on the FYE 200**6** cost report with service dates between 2001 and 2006 and noted an *extrapolated* error of $106,743.

The Medicare Contractor accepted the Provider's as-filed 200**9** cost report on June 25, 2010 and the Provider's amended 200**9** cost report on May 9, 2011. The Medicare Contractor contends that there was no legal impediment preventing the Provider from claiming the disputed bad debts on its 200**9** as-filed cost report or its amended cost report:

> More significantly, the Provider was not barred from claiming the disputed bad debts. Indeed, the record shows the Provider's belief that the disputed bad debts are allowable and that the MAC has the authority or discretion to make payment in the manner being sought. Here the MAC points to the Provider's appeal request, wherein the Provider states, "Provider agrees with MAC's assertion that bad debt should be included in the FYE 12/31/09 cost report since bad debt was returned from collection agency on Jan. 10, 9 2009 (see Exhibit II). This treatment is in accordance with CMS PUB.15-1 Sec. 310 & 314."

Accordingly, the Medicare Contractor maintains that the Board does not have jurisdiction over this issue under 42 U.S.C. § 1395oo(a), because the Provider neither claimed nor protested the

disputed bad debts, and the Provider is unable to show that there was a good faith belief that it would be futile to include them on their as-filed cost report.[2]

Provider's Position

Issue No. 9 2006 Inpatient Agency Bad Debt

The Provider asserts that the adverse determination originated in FY 2006 when Medicare Contractor removed the extrapolated bad debt of $106,743, which represents the extrapolated (not the actual) value of a "timing issue." The Provider notes that it timely appealed the bad debt removal in both its FY 2006 and FY 2009 appeals and that it repeatedly discussed the Medicare Contractor's bad debt removal with the Medicare Contractor's auditors who allegedly assured the Provider that all the proper appeal procedures had been met for proper inclusion of bad debt in FY 2009. In support of its position, the Provider notes that the Medicare Contractor's Preliminary Position Paper does not contain any allegation that the Provider failed to meet the "dissatisfaction" requirement.

The Provider maintains that it preserved its appeal rights by contesting Medicare Contractor's bad debt policy change in its FY 2009 as-filed cost report. Specifically, the Provider points to the following statement it made in the cover letter to its FY 2009 as-filed cost report (at p. 2, Item D): "…Trailblazer has implemented CMS instruction and policy regarding the disallowance of bad debt claims for reimbursement on those claims that were sent to a collection agency for further collection efforts *at the time they were claimed for reimbursement* …The Methodist Hospital believes, however, that our bad debt policy regarding transfers to collection agencies and allowance of those claims on the cost report on the date of their transfer are protected under the Bad Debt Moratorium from the Omnibus Budget Reconciliation Act of 1989 (OBRA)…"[3]

The Provider notes that the NPR for FY 200**6** was issued on December 4, 2010 and, in contrast, that the FY 200**9** cost report was filed on May 28, 2010, well before the NPR for FY 2006 was issued. As such, the Provider maintains that there was no way it to have included the disallowed bad debt account on the FY 2009 as-filed cost report. The Provider also states it brought the issues to the Medicare Contractor's attention during FY 2009 cost report audit. However, rather than incorporating this adjustment in its NPR, the Provider alleges that the Medicare Contractor verbally instructed the Provider to include this issue in FY 2009 appeal.[4]

Board Decision

The Board finds that it does not jurisdiction over the FY 2006 Bad Debts issue. Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1841 (2009), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy

[2] See Medicare Contractor's Jurisdictional Challenge dated March 9, 2021
[3] (Emphasis added.)
[4] See Provider's Jurisdictional Response dated April 6, 2021

is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

At issue in this jurisdictional dispute is the dissatisfaction requirement for Board jurisdiction. 42 C.F.R. § 405.1835(a)(1)(2013) dictates that a provider must preserve its right to claim dissatisfaction with the amount of Medicare payment for the specific items at issue, by either –

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

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

> …when a provider fails to present a claim in its cost report that [a Medicare contractor] can address, it can be deemed "satisfied" with the amounts requested in the cost report and awarded by the [Medicare contractor]. But where the [Medicare contractor] has no authority to address a claim, such as when a pure legal challenge to a regulation is at issue, a provider cannot be deemed to be "satisfied" simply because such challenge is not reflected in the cost report. Satisfaction cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the [Medicare contractor].[5]

The *Banner* court looked to *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*")[6] which also addressed a challenge to a regulation which was not first presented to the Medicare contractor. *Bethesda* holds that a provider need not protest self-disallowed costs that are barred from being claimed because of a specific statute, regulation, or ruling. *Id.* at 404. The Supreme Court in *Bethesda* stated:

> . . . [T]he submission of a cost report in full compliance with the unambiguous dictates of the Secretary's rules and regulations does not, by itself, bar the provider from claiming dissatisfaction with the amount of reimbursement allowed by those regulations. No

[5] *Banner* at 141.
[6] 485 U.S. 399 (1988).

> statute or regulation expressly mandates that a challenge to the validity of a regulation be submitted first to the [Contractor]. Providers know that, under the statutory scheme, the [Contractor] is confined to the mere application of the Secretary's regulations, that the [Contractor] is without power to award reimbursement except as the regulations provide, and that any attempt to persuade the [Contractor] to do otherwise would be futile.[7]

CMS issued Ruling CMS-1727-R ("Ruling 1727") to state its policy to follow the holding in *Banner Heart Hospital v. Burwell*, 201 F. Supp. 3d 131 (D.D.C. 2016). Ruling 1727 sets out a five-step analysis for the Board to undertake to determine whether a provider is entitled to a hearing for an item that the provider appealed but did not include on its cost report. In short, a provider has a right to a Board hearing for a cost item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or *other policy* that gave the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[8]

The first step of analysis under Ruling 1727 involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. In the instant case, the Board received the Provider's request for hearing on September 29, 2015, which is before the date of April 23, 2018, thus the appeal satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. This appeal involves a fiscal year end December 31, 2009 cost report, thus the appealed cost reporting period falls within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[9] The regulations governing bad debt are located at 42 C.F.R. § 413.89. Subsection (a) states the general rule that bad debts are deductions from revenue and are not to be included in allowable Medicare costs. However, subsection (d) allows reimbursement for bad debts attributable to Medicare deductibles and coinsurance in order to ensure that costs associated with care furnished to Medicare beneficiaries are not borne by non-Medicare patients.

42 C.F.R. § 413.89(e) provides the criteria that bad debts must meet in order to be allowable. When the FY 2009 cost report was filed, this regulation stated the following criteria:

> (1) The debt must be related to covered services and derived from deductible and coinsurance amounts.
>
> (2) The provider must be able to establish that reasonable collection efforts were made.

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[7] *Bethesda* at 404.
[8] Ruling 1727 at unnumbered page 2 (emphasis added).
[9] Ruling 1727 at 6.

(3) The debt was actually uncollectible when claimed as worthless.

(4) Sound business judgment established that there was no likelihood of recovery at any time in the future.[10]

Additional guidance on the Medicare bad debt requirements is located in Chapter 3 of the Provider Reimbursement Manual, CMS Pub. 15, Part 1 ("PRM 15-1"). PRM 15-1 § 308 mirrors 42 C.F.R. § 413.89(e) in outlining the four criteria that must be satisfied in order for bad debts to be eligible for reimbursement by Medicare. PRM 15-1 § 310 provides guidance as to what constitutes reasonable collection efforts. PRM 15-1 § 310.2 sets forth the "Presumption of Noncollectability," providing that, "[i]f after reasonable and customary attempts to collect a bill, the debt remains unpaid more than 120 days from the date the first bill is mailed to the beneficiary, the debt may be deemed uncollectible."

In § 4008(c) of the Omnibus Budget Reconciliation Act of 1987, Congress enacted a non-codified statutory provision that became known as the "Bad Debt Moratorium." In § 8402 of the Technical and Miscellaneous Revenue Act of 1988, Congress retroactively amended the Bad Debt Moratorium. Finally, in § 6023 of the Omnibus Budget Reconciliation Act of 1989, Congress again retroactively amended the Bad Debt Moratorium. As a result of these serial amendments, the Bad Debt Moratorium reads:

> CONTINUATION OF BAD DEBT RECOGNITION FOR HOSPITAL SERVICES.— In making payments to hospitals under title XVIII of the Social Security Act, the Secretary of Health and Human Services shall not make any change in the policy in effect on August 1, 1987, with respect to payment under title XVIII of the Social Security Act to providers of service for reasonable costs relating to unrecovered costs associated with unpaid deductible and coinsurance amounts incurred under such title (including criteria for what constitutes a reasonable collection effort, including criteria for indigency determination procedures, for record keeping, and for determining whether to refer a claim to an external collection agency). The Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigency determination procedures, record keeping, and determining whether to refer a claim to an external collection agency, has accepted such policy before that date, and the Secretary may not collect from the hospital on the basis of an expectation of a change in the hospital's collection policy.

[10] The Board recognizes that, as part of the FY 2021 IPPS Final Rule, CMS *retroactively* codified certain changes to the bad debt regulations and that these changes included codify CMS policy that, before claiming an unpaid amount as a Medicare bad debt, the provider must cease all collection efforts, including any collection agency efforts (i.e., a bad debt at a collection agency must be returned to the provider prior to claiming it as a bad debt). 85 Fed. Reg. 59023 (Sept. 18, 2020). However, these regulatory changes are not relevant since it is clear that the bad debts at issue *had been returned* from a collection agency in FY 200**9**.

Here, the Provider has not pointed to (nor has the Board identified) any bad debt regulations or rule that prevented the Provider from claiming the bad debts at issue on either the as-filed FY 2009 cost report or the FY 2009 amended cost report. The Board recognizes that, in the cover letter to its FY 2009 cost report filing, the Provider challenged CMS' policy of disallowing bad debts still at a collection agency. However, the Provider concedes that the bad debts at issue ***had been returned*** from the collection agency ***during FY 2009***[11] and, as such, that challenge is ***not*** applicable or relevant to the bad debts at issue.[12] Thus, the Board finds the bad debts at issue in this appeal were ***not*** "subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment *in the manner sought by the provider*" for the fiscal year at issue (*i.e.*, FY 2009).[13]

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in 42 C.F.R. § 405.1835. As the Provider's appeal was timely filed and the estimated amount in controversy is over $10,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, *i.e.*, an "allowable" item. In the instant appeal, the disputed bad debts were within the payment authority or discretion of the Medicare Contractor.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, the bad debts at issue were ***not*** subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment. Therefore, the Board the "the self-disallowance jurisdiction regulation" is ***not*** applicable.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. The Provider claims they self-disallowed the bad debts at issue based on the direction of the Medicare Contractor:

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[11] The issue statement for Issue 9 in the Provider's appeal request filed on September 29, 2015 to establish Case No. 15-3458 is: "MAC should incorporate a 2006 inpatient bad debt *which was returned* from the collection agency in 200**9**." (Emphasis added.) The Provider included the same issue statement for Issue 9 in its preliminary position paper.

[12] While the Board is recognizing that the existence of the challenge to the policy in the cover letter to the FY 2009 as-filed cost report, the Board is not making any findings with respect to whether that challenge was a *proper* "protested item" because that question is moot and not germane to the bad debts at issue. That said, the Board notes that the record shows that the cover letter did not quantify the challenge and ***no*** bad debts (including but not limited to the bad debts at issue) were listed as a protested item on the FY 2009 cost report and, as a result, the Board would have concerns about whether it was proper and complied with the instructions included at PRM 15-2 § 115.

[13] (Emphasis added.)

> MAC is incorrect since Provider did, in fact, preserved its appeal rights. Provider preserved its appeal rights by contesting MAC's bad debt policy change in Provider's 2009 filed cost report. Provider's 2009 filed cost report's cover letter, Page 2, Item D, states in part, "…Trailblazer has implemented CMS instruction and policy regarding the disallowance of bad debt claims for reimbursement on those claims that were sent to a collection agency for further collection efforts at the time they were claimed for reimbursement …The Methodist Hospital believes, however, that our bad debt policy regarding transfers to collection agencies and allowance of those claims on the cost report on the date of their transfer are protected under the Bad Debt Moratorium from the Omnibus Budget Reconciliation Act of 1989 (OBRA)…" (See Exhibit V).
>
> MAC is correct in stating that the $337,370 Protested amount does ***not*** quantify Provider's collection agency policy issue. However, Provider contends that providers are not required to quantify policy issues. Provider contents that it is only required to identify the protested issue. Contrary to MAC's assertion, HMH did, in fact, protest Bad Debt Issue 9.

However, as explained above, the Provider's focus on CMS' policy regarding bad debts still at a collection is a red herring because the bad debts at issue had been returned to the Provider and could have been claimed on the FY 2009 as-filed cost report or the FY 2009 amended cost report. Indeed, the Provider appears to recognize this point in its issue statement for Issue 9 included in its appeal request for Case No. 15-3458 filed on September 29, 2015:

> Provider ***agrees*** with MAC's assertion that bad debt should be included in the FYE 12/31/09 cost report *since bad debt was returned from collection agency on Jan. 10, 9 2009* (see Exhibit II). This treatment is in accordance with CMS PUB.15-1 Sec. 310 & 314.

Thus, it appears as if the Provider included the bad debts at issue in error on its FY 2006 cost report as opposed its as-filed FY 2009 cost report. The Board notes that the Medicare Contractor issued the FY 2006 NPR on December 4, 2010 and that the Medicare Contractor accepted the Provider's FY 2009 amended cost report on May 9, 2011. As a result, it is clear that the Provider had time to correct its error and include the bad debts at issue in the amended FY 2009 cost report. As such, the Board finds that the Provider was not barred from claiming the bad debts as issue and submitting them as part of either the as-filed or amended cost report for FY 2009.

In summary, the Board finds that, based upon Ruling 1727-R, it does not have jurisdiction over the bad debts issue because it would ***not*** have been futile to present the bad debts at issue to the Medicare Contractor in its as-filed ***or*** amended cost report for FY 200**9**. Accordingly, the Board hereby, dismisses the 2006 bad debts at issue from the subject appeal.

Case No. 15-3458 remains open for the revenue code 810 charge issue. The case is scheduled for hearing on November 17, 2021. 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

FOR THE BOARD:

11/16/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: *EJR Determination*
Case No. 20-2020GC: *Hackensack Meridian CY 2017 Direct Graduate Medical Education Penalty to FTE Count CIRP Group*
Case No. 21-0212GC: *UPMC Hosp. Network CY 2018 DGME Penalty to FTE Count CIRP Grp.*
Case No. 21-0214GC: *Premier Health Partners CY 2017 Direct Graduate Medical Education Penalty to FTE Count CIRP Group*
Case No. 21-0326GC: *Premier Health Partners CY 2018 Direct Graduate Medical Education Penalty to FTE Count CIRP Group*
Case No. 21-0678G: *Baker Donelson CYs 2010, 2015, 2017 & 2018 Direct Graduate Med Education (DGME) Penalty to FTE Count Group*
Case No. 21-1189GC: *Hackensack Meridian CY 2018 Direct Graduate Med Education (DGME) Penalty to FTE Count CIRP Group*
Case No. 21-1305GC: *Northwell Health CY 2016 Direct Graduate Med Education (DGME) Penalty to FTE Count CIRP Group*
Case No. 21-1314GC: *Univ. of PA Health System CY 2019 Direct Graduate Med Education (DGME) Penalty to FTE Count CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' October 1, 2021 request for expedited judicial review ("EJR") in the above-referenced individual appeal.[1] The decision of the Board is set forth below.

Issue in Dispute

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

> Whether the Medicare Administrative Contractor ("MAC") must correct its determinations of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency periods ("IRPs") used for determining payments for direct graduate medical education ("DGME").

[1] The EJR request covered 13 appeals, 10 group appeals and 3 individual appeals. The Board issued EJR decisions for appeals with cost reporting periods, where each fiscal year ended prior to 12/31/2016 in five appeals (the 3 individual appeals and 2 group appeals) on 10/18/21. This determination covers the remaining 8 appeals in the EJR request.

***

> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, 42 U.S.C. § 1395ww(h)(4)(C). The Provider disputes the computation of the current, prior and penultimate weighted DGME FTEs and the FTE cap. CMS's implementation of the cap and weighting factors is contrary to the statute, because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Provider from claiming FTEs up to its full FTE caps. See 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME caps are set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and residents beyond the IRPs are weighted at no more than 0.5. The Provider self-disallowed the amount at issue, because the MAC was bound to deny payment pursuant to the regulation at 42 C.F.R. § 413.79(c)(2), and the Provider challenges that regulation. See CMS-1727-R.

Background

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

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

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

[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).

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

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

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

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

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

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

[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

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

> most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31,

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

> 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

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

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

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

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

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

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

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

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

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

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

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).

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

The Providers' Position

The Providers are teaching hospitals that receive DGME payments and, during the cost years under appeal, their FTE counts exceeded their FTE caps.[17] The Providers also trained fellows and other residents who were beyond the IRP. The Providers are requesting the Board grant EJR based on a challenge to:

> the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the [DGME] cap on [FTE] residents and the FTE weighting factors. The regulation at 42 C.F.R. § 413.79(c)(2) is contrary to the statute because it determines the cap after application of weighting factors. The effect of the unlawful regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the initial residency period ("IRP"), and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute (hereinafter, the "fellowship penalty"). Thus, the calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and, as a result, the Providers' DGME payments are understated.[18]

The Providers argue that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FREs are capped before application of weighting factors.[19] They claim that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this statute because it determines a cap after application of the weighting factors to fellows in the current year.[20] Second, they argue that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[21] Finally, Providers claim "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[22]

The Providers allege that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the Providers from reaching their FTE caps and

[17] Providers' Petition for Expedited Judicial Review at 8 (Oct. 1, 2021) ("EJR Request").
[18] *Id.* at 1 (citations omitted).
[19] *Id.* at 11.
[20] *Id.* at 11-12.
[21] *Id.* at 12-13.
[22] *Id.* at 14.

treats similarly situated hospitals differently.[23] Finally, the Providers state that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[24]

The Providers claim that they meet the jurisdictional dissatisfaction requirement for this issue pursuant to CMS Ruling 1727-R and because they self-disallowed the amount sought based on the Medicare Contractor being bound by regulation.[25] They argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant their request for EJR.[26]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2011), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[27] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[28]

On August 21, 2008, new regulations governing the Board were effective.[29] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell*

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[23] *Id.* at 16.
[24] *Id.* at 17 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-2628 (May 17, 2021).
[25] *Id.* at 8.
[26] *Id.* at 17-18.
[27] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[28] *Bethesda*, 108 S. Ct. at 1258-59.
[29] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[30] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[31]

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

The Board has determined that: (1) the Providers in the above referenced cases with cost reports beginning prior to January 1, 2016 and involved with the instant EJR request involve cost report periods which are governed by CMS Ruling CMS-1727-R; (2) these Providers had the right to appeal under 1727-R because they are challenging a regulation; and (3) each of these Providers' appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the underlying providers with cost reports beginning prior to January 1, 2016.

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

The remaining Providers appealed from cost reporting periods beginning on or after January 1, 2016 and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[32] The Board notes that the November 13, 2015 OPPS Final Rule *eliminated* the ***jurisdictional*** requirement of provider dissatisfaction in existing §§ 405.1835(a)(1) and 405.1840(b)(3) for Board appeals of cost reporting periods beginning on or after January 1, 2016.[33]

Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must

[30] 201 F. Supp. 3d 131 (D.D.C. 2016).
[31] *Id.* at 142.
[32] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[33] 80 Fed. Reg. 70298 (Nov. 13, 2015).

include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[34]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[35] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[36]

In this case, on October 7, 2021, the Board issued a Request for Information ("RFI") for either party to raise a question under 42 C.F.R. § 405.1873(a) or 42 C.F.R. § 413.24(j). On October 19, 2021, the Medicare Contractor replied to this RFI stating that it has not identified any substantive claim challenges to any of the participants in the above referenced cases.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[37] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. The Board finds that each of the providers timely and properly appealed.

C. *Jurisdiction over the Groups*

Finally, the participants' documentation in the EJR requests shows that: (1) the estimated amount in controversy exceeds $50,000 in each group case, as required for group appeals;[38] and (2) the Board has substantive jurisdiction over the issue raised in the group appeals. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers for providers and, accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d). Note that the estimated amount in controversy will be subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[34] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[35] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[36] *See* 42 C.F.R. § 405.1873(a).
[37] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[38] *See* 42 C.F.R. § 405.1835.

D. Board's Analysis of the Appealed Issue

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

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [39]

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[40] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[41] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

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[39] EJR Request at 4.
[40] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[41] 66 Fed. Reg. at 39894 (emphasis added).

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[42]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[43] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[44] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[45] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[46]

---

[42] (Emphasis added.)
[43] *See* 62 Fed. Reg. at 46005 (emphasis added).
[44] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[45] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.
[46] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

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

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

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

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

E. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in these appeals[47] are entitled to a hearing before the Board;

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

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

[47] The Board notes that the Schedule of Providers attached to this decision includes, for each participant, all provider numbers associated with the health complex for that participant (*e.g.*, subsection (d) hospital, IRF, SNF, HHA). However, for purposes of this EJR determination, the only provider number relevant for each participant is provider number included on the appeal request and associated NPR at issue, namely the provider number associated with the subsection (d) hospital for the hospital complex.

4) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

Board Members Participating:

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

FOR THE BOARD:

11/16/2021

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Bruce Snyder, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators
Dana Johnson, Palmetto GBA c/o National Governments Services, Inc.
Danelle Decker, National Government Services, Inc)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Mr. Neil Sullivan
Greenbaum, Rowe, Smith & Davis, LLC
75 Livingston Avenue
Roseland, NJ 07068

RE: **Board Determination re: Timely Filing of Appeal**
Care Point Health – Hoboken University Medical Center
Provider No.: 31-0040
FFY 2021
PRRB Case No.: 22-0095

Dear Mr. Sullivan:

The above-captioned appeal was submitted via the Office of Hearings Case and Document Management System ("OH CDMS") on November 2, 2021 and is based on the Notice of Quality Reporting Program Noncompliance Decision Upheld dated September 11, 2020 for the Federal Fiscal Year ("FFY") 2021. The Board assigned case number 22-0095 to the appeal request. The Board's determination regarding the jurisdiction of the subject appeal is set forth below.

Facts:

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 contractor's final determination, the amount in controversy is $10,000 or more (or $50,000 for a group), and the **request for a hearing is filed within 180 days of the date of receipt of the final determination**.

Board Rule 4.3.1 states, in part:

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

Board Rule 4.5.A states, in part:

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

generated by the system.

Board Determination:

The subject appeal was submitted via OH CDMS on November 2, 2021 with a final determination date of September 11, 2020. Pursuant to the rules and regulations cited above, the Provider had 180 days of the date of receipt of the final determination to file an appeal with the Board, or no later than March 15, 2021. The Board notes that the subject appeal request was not submitted until November 2, 2021, 417 days from the date of the final determination, September 11, 2020.

The Board hereby determines that the subject appeal was not timely filed in accordance with the Board Rules and 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840. The Board hereby dismisses the subject appeal in its entirety and removes it from its docket.

Board Members:

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

FOR THE BOARD:

11/17/2021

X Gregory H. Ziegler

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

cc: Wilson C. Leong, Federal Specialized Services
Bruce Snyder, Novitas Solutions, Inc. (J-L)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
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Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Nancy Repine
West Virginia University Health System
3040 University Ave.
P.O. Box 8261
Morgantown, WV 26506

RE: ***Jurisdictional Decision***
City Hospital, Inc. (Prov. No. 51-0008)
FYE 12/31/2015
Case No. 19-1760

Dear Ms. Repine,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal and finds that it does not have jurisdiction over the DSH/SSI – Provider Specific issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On March 7, 2019, City Hospital, aka Berkeley Medical Center, appealed an original Notice of Program Reimbursement ("NPR") dated September 4, 2018, for its fiscal year end ("FYE") December 31, 2015 cost reporting period. The appeal request included the following issues:[1]

- Issue 1: Disproportionate Share Hospital Payment (DSH) – Supplemental Security Income ("SSI") Percentage (Provider Specific);
- Issue 2: DSH – SSI (Systemic Errors);
- Issue 3: Predicate Fact – Inpatient Prospective Payment System (IPPS) Diagnostic Related Group (DRG) – Inpatient (I/P) Discharges/Transfers.[2]

On October 22, 2019, the Provider transferred Issue 2 (DSH – SSI (Systemic Errors)) to Group Case No. 20-0064GC and Issue 3 (IPPS DRG I/P Discharges/Transfers) to Group Case No. 19-0065GC. Accordingly, Issue 1 is the only remaining issue.

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

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (Mar. 7, 2019).
[2] *Id*.

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.[3]

Similarly, the Provider described Issue 2, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 20-0064GC, as follows:

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

[3] *Id.* at Issue 1.

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

On June 13, 2021, the Provider filed its final position paper and the following is the Provider's ***complete*** position on Issue 1 for the "Calculation of the SSI Percentage" that is set forth therein:

> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (December 31).

[4] *Id* at Issue 2.

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

On January 13, 2020, the Medicare Contractor filed a Jurisdictional Challenge regarding Issue No. 1 addressing the DSH Supplemental Security Income ("SSI") Percentage (Provider Specific) issue.[5] The MAC contends Issue 1 should be dismissed from this case. According to the Provider's individual appeal request dated February 26, 2019, Issue 1 had three sub-components: 1) SSI data accuracy; 2) SSI realignment; and 3) individuals who are eligible for SSI but did not receive SSI payment. The Provider did not brief components 2 and 3 in its preliminary position paper; therefore, the Board should consider these components as withdrawn by Provider in accordance with Rule 25.3, which requires that "[a]ny issue not briefed by the Provider in its position paper will be considered withdrawn."

The MAC contends Issue 1, which now only contains the SSI data accuracy sub-component, should be dismissed as it is duplicative of Issue 2, which was transferred to Group Case number 20-0064GC, WVU Medicine CY 2015 DSH SSI Percentage CIRP Group.[6]

The Provider did ***no***t file a response to the jurisdictional challenge. Per Board Rule 44.4.3: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

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[5] MAC's Jurisdictional Challenge, at 1 (Jan. 13, 2020).
[6] Issue 2 was transferred to group case number 20-0064GC, WVU Medicine CY 2015 DSH SSI Percentage CIRP Group on October 22, 2019.

Board 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 costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group case no. 20-0064GC, *WVU Medicine CY 2015 DSH SSI Percentage CIRP Group*.

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) that was transferred to Case No. 20-0064GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[7] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9]

The Provider's Issue 2, transferred to the group under Case No. 20-0064GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 in Case No. 20-0064GC. Because the issue is duplicative, and duplicative issues appealed from the

[7] Individual Appeal Request, Issue 2.
[8] *Id.*
[9] *Id.*

same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 20-0064GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[10] The Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-0064GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper filed on November 1, 2019 to see if it further clarified Issue 1. However, the briefing of this issue was a mere 5 sentences long without any exhibits and failed to provide any basis upon which to distinguish Issue 1 from Issue 2. Instead, it refers generically to the systemic *Baystate* data matching issues that are the subject of Issue 2:

> Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[11] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Final Position Paper and include *all* exhibits.

---

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

[11] (Emphasis added.) Similarly, the Commentary at Board Rule 25 states that position papers "are expected to present ***fully developed*** positions of the parties" and Board Rule 25.3 states: "Parties should file with the Board a *complete* preliminary position paper *with a* ***fully developed*** *narrative* (Rule 23.1), ***all*** *exhibits* (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn."

The Board recognizes that the Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[12] However, in the Preliminary Position Paper, the Provider simply states that "at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. See 65 Fed. Reg. 50,548 (2000)." However, the Provider fails to give a sufficient status update in the Preliminary Position Paper since it filed its initial appeal was filed in direct violation of Board Rule 25.2.2:

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

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

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

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

Accordingly, the Board must find that Issues 1 and 2, which was transferred to Group Case No. 20-0064GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its Preliminary Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

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

[12] (Emphasis added.)

use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. As there are no more pending issues in the appeal, Case No. 19-1760 is closed and removed from the Board's docket.

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

Board Members Participating:

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

For the Board:

11/17/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

William Galinsky
Baylor Scott & White Health
2401 South 31st St.
MS-AR-M148
Temple, TX 76508

RE: ***Notice of Dismissal***
Baylor Scott & White Medical Center Garland (Prov. No. 45-0280)
FYE 12/31/2013
Case No. 19-1172

Dear Mr. Galinsky:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the documents filed in the above captioned case. The Medicare Contractor has filed a Motion to Dismiss, and the decision of the Board is set forth below.

Background

On January 22, 2019, the Board received Provider's Individual Appeal Request appealing their July 20, 2018 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2013. The initial appeal contained the eight (8) following issues:

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

In August 20189, the Provider transferred Issues 2, 3, 4, 6, 7, and 8 to group appeals. On November 3, 2020, the Board dismissed Issue 1. As a result, the only remaining issue is Issue 5 concerning DSH – Medicaid Eligible Days.

On September 23, 2021, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to provide an eligibility listing of the additional days being claimed on appeal. It outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The

Medicare Contractor also points to 42 C.F.R. § 413.24(c), which places the burden production on the Provider with regard to furnishing this documentation. Finally, it notes that both the Provider's Preliminary and Final Position Papers state that *an eligibility listing was being sent under separate cover*. The Medicare Contractor claims that no listing has ever been provided to it in the six (6) years since the amended cost report was filed, despite repeated requests being made to the Provider for such a listing.

The Provider has not, to date, filed a response to the Medicare Contractor's Motion to Dismiss. The Board Notes that Board Rule 44.3 gave the Provider 30 days to respond to the Motion: "Unless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Relevant Law

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Aug. 2018) states:

> The provider must support the determination being appealed and the basis for its dissatisfaction for each issue under appeal. *See* subsections below and Rule 8 for special instructions regarding multi-component disputes.
>
> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[1] Board Rule 25.2.1 requires that "the parties must exchange ***all*** available documentation as exhibits to fully support your position."[2] Similarly, the Commentary to Board Rule 23.3 states the following regarding preliminary position papers which is equally applicable to final position papers through operation of Board Rule 27.2: "Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, the Board requires preliminary position papers to be ***fully*** *developed and include* ***all*** *available documentation necessary to provide a* ***thorough*** *understanding of the parties' positions*."[3] Board Rule 25.2.2 continues to provide the following instruction on the ***content*** of position papers:

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

[1] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.
[2] (Emphasis added.)
[3] (Emphasis added.)

> Once the documents become available, promptly forward them to the Board and the opposing party.[4]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

Additionally, and more generally related to accounting records and reporting requirements for providers, 42 C.F.R. § 413.24(c) describes what cost information is adequate:

> Adequate cost information must be obtained from the provider's records to support payments made for services furnished to beneficiaries. The requirement of adequacy of data implies that the data be accurate and in sufficient detail to accomplish the purposes for which it is intended.

Finally, Board Rule 41.2 permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- 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.

Decision of the Board

The Board concurs with the Medicare Contractor that the Provider is required to provide documentation to prove what additional Medicaid Eligible days to which it may be entitled. Pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[5] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, and noting that the Provider has been provided sufficient opportunity to rebut the Medicare Contractor's claims,[6] the Board finds that the Provider has failed to provide a listing or other supporting

[4] (Emphasis added.)
[5] (Emphasis added.)
[6] *See* Board Rule 44.4.3.

documentation for the Medicaid Eligible days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable.[7] In this regard, the Board notes that the Provider represented in its final position paper filed on September 7, 2021 that "the Listing of Medicaid Eligible days [was] being sent under separate cover."[8] However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready. Similarly, the Board notes that this appeal has been pending for nearly three (3) years, that the Provider has failed to respond to the Medicare Contractor's requests for a Medicaid Eligible days listing, and that the Provider failed to respond to the Medicare Contractor's Motion to Dismiss.

For the above reasons, the Board hereby dismisses the Medicaid Eligible days issue from Case No. 19-1172 and removes this case 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:

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Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
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For the Board:

11/23/2021

X Clayton J. Nix

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Chair
Signed by: PIV

cc: Wilson C. Leong, Esq. Federal Specialized Services
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[7] Board Rule 25, of which 25.2.1 and 25.2.2, are a part is applicable to final position papers via Board Rule 27.2.
[8] Final Position Paper at 8.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Seton Medical Center – Harker Heights (Prov. No. 67-0080)
FYE9/30/2017
Case No. 17-1149

Dear Mr. Hettich,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above-referenced common issue related party ("CIRP") group appeal. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

On February 17, 2017, the Provider filed their appeal request challenging the Final Rule in the Federal Register issued on August 22, 2016.[1] The Provider's appeal focuses on whether its DSH payment contained a calculation error related to the third factor ("Factor 3") used to determine the payment for its proportion of uncompensated care. Specifically, the Provider has framed two issues as follows:

Issue 1: Whether CMS's failure to exclude the time period for which a hospital had no Medicaid eligible days and failure to use a full 12-month cost reporting period to determine the number of the Provider's Medicaid eligible days in calculating a portion of Factor 3 of the Provider's FY 2017 uncompensated care ("UCC") payment was lawful?

Issue 2: Whether CMS erred and acted beyond its authority, i.e., *ultra vires*, by failing to effectuate the D.C. circuit's *Allina* decision when it calculated factor 3 in the Provider's UCC payment.[2]

For Issue 1, the Provider points out that, for FY 2017, CMS stated it would average the data from 2011, 2012, and 2013 cost reports to determine a provider's Factor 3 value, and that if a hospital does not have data for one or more of those periods, CMS would compute Factor 3 for the periods available and average those. Provider goes on to note that it was a new facility opening

[1] Individual Appeal Request, Tab 1 (Feb. 17, 2017); 81 Fed. Reg. 56762 (Aug. 22, 2016).
[2] Individual Appeal Request, Tab 3 at 1-3.

June 27, 2012 and, as such, there are no 2011 Medicaid eligible days data available for the Provider's newly assigned Provider Number. Nevertheless, Provider claims that, rather than exclude 2011 because no data was available, CMS included a "zero" for 2011 when averaging its Medicaid eligible days cost report data.[3]

Furthermore, CMS used the Medicaid days from a shortened cost reporting period ("stub-period") for 2012 to calculate its UCC adjustment amount. Provider claims that CMS is statutorily required to calculate the UCC payment for each hospital "for a period selected by the Secretary," and that comparing the days in a stub-period for Provider to a full twelve-month period for other providers employs different "periods" in violation of that statutory requirement.[4] Provider also argues that the use of a stub-period violates the statutory requirement that any "estimate" used by the Secretary be "based on appropriate data." It claims that this practice arbitrarily penalizes certain providers with "stub-periods."[5] Finally, Provider argues that it is not being provided the same protection afforded to Indian Health Service ("IHS") hospitals. It notes that, originally, because cost reports for IHS hospitals are not uploaded to HCRIS, the UCC payments calculated by CMS understated the amount of uncompensated care that IHS hospitals provide. CMS later revised its policy to consider supplemental cost report data in determining Factor 3 to allow the Medicaid days for HIS hospitals to be included.[6]

For Issue 2, Provider discusses *Allina Health Servs. v. Sebelius*, 746 F.3d 1102 (D.C. Cir. 2014) ("*Allina*") with regard to the calculation of Factor 3 of the UCC payment, reiterating the argument that SSI days should exclude Medicare Advantage ("MA") days, and MA dual eligible days should be included as Medicaid days in the FY 2017 Factor 3 calculation. Provider points out CMS' position that it does not believe *Allina* has any bearing on the estimate of Factor 3 for FY 2017 since it had readopted the policy of counting MA says in the SSI ration for FY 2014 and beyond. Provider argues that this policy still relies on SSI and Medicaid data from a period predating this re-adopted policy, and that CMS was obligated to correct those numbers to confirm with the Court's ruling in *Allina*. Provider contends that this approach results in CMS acting beyond its authority by continuing to treat Part C days as "days entitled to benefits under Part A" for periods pre-dating their re-adopted policy.[7]

The Medicare Contractor ("MAC") filed a Jurisdictional Challenge in this case on April 16, 2018. The MAC argues that both issues are precluded from administrative and judicial review pursuant to 42 U.S.C. § 1395ww(r)(3). It argues that the bar against administrative and judicial review is sufficiently broad to divest the Board's authority to decide the issues raised by the Provider in this appeal.[8]

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[3] *Id.* at 1-2.
[4] *Id.* at 3.
[5] *Id.*
[6] *Id.* (citing 78 Fed. Reg. 61191, 61195 (Oct. 3, 2013)).
[7] *Id.* at 2-3. *See also* 79 Fed. Reg. 49853.
[8] Medicare Administrative Contractor's Jurisdictional Challenge at 2 (Apr. 16, 2018).

The Provider filed a Response to the MAC's Jurisdictional Challenge on May 16, 2018. It argues that CMS failed to use "appropriate data" in calculating Factor 3 for its FY 2017 UCC DSH payment as required by § 1886(r) of the Social Security Act because its own policy required that data be used from FYs 2011, 2012, and 2013 "when applicable," but that, since the Provider began operating in 2012, it had no data for FY 2011. The Provider argues that CMS should have excluded FY 2011 from its UCC DSH payment calculation, rather than include a "zero" in the average.[9] It points to language from the federal register stating that "if the hospital does not have data for one or more of the three cost reporting periods, [CMS] will compute Factor 3 for the periods available and average those."[10] The Provider insists that it is not challenging the estimates made or time period selected in calculating Factor 3, but rather CMS' failure to follow its own policy in calculating its Medicaid-eligible days.[11] Finally, Provider states that CMS has acted *ultra vires* by counting patient days under Part C as "days entitled to benefits under Part A" in calculating its SSI ratio, contrary to the holding in *Allina*.[12]

Relevant Law and Analysis:

A. Bar on Administrative Review

The Board does not generally have jurisdiction over Uncompensated Care DSH payment issues because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. Based on these provisions, judicial and administrative review is precluded under 42 U.S.C. §§ 1395ff and 1395oo for:

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[13]
>
> (B) Any period selected by the Secretary for such purposes.

B. Interpretation of Bar on Administrative Review

1. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs.* ("*Tampa General*"),[14] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C.

[9] Provider's Jurisdictional Response at 1 (citing 81 Fed. Reg. 56762, 56957-56958 (Aug. 22, 2016)).
[10] *Id.*
[11] *Id.* at 4.
[12] *Id.* at 2, 6.
[13] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[14] 830 F.3d 515 (D.C. Cir. 2016).

Circuit") upheld the D.C. District Court's decision[15] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[16] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[17]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[18]

2. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[19] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[20] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is

[15] 89 F. Supp. 3d 121 (D.D.C. 2015).
[16] 830 F.3d 515, 517.
[17] *Id.* at 519.
[18] *Id.* at 521-22.
[19] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[20] *Id.* at 506.

"inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[21]

3. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[22] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[23] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[24] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[25] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[26]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[27]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the

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[21] *Id.* at 507.
[22] 514 F. Supp. 249 (D.D.C. 2021).
[23] *Id.* at 255-56.
[24] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[25] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[26] *Id.*
[27] *Id.* at 262-64.

estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[28] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[29] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[30]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[31] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

4. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[32] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[33] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[34] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[35] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[36]

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[28] *Id.* at 265.
[29] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[30] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[31] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[32] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[33] *Id.* at *4.
[34] *Id.* at *9.
[35] 139 S. Ct. 1804 (2019).
[36] *Ascension* at *8 (bold italics emphasis added).

Board Decision:

With regard to any argument that the Secretary could have used more accurate or recent data to calculate any portion of Provider's 2017 Uncompensated Care payments, the Board finds that the same findings from *Tampa General* are applicable. The Provider is challenging the inclusion and/or exclusion of certain days and/or data in the estimates used by the Secretary, as well as the use of a stub-period cost report. The Board finds in challenging data included or excluded in calculating its Factor 3 values, the Provider is seeking review of an "estimate" used by the Secretary to determine the factors used to calculate their final payment amounts. The Board finds in essence, the Provider is challenging the underlying data relied on by the Secretary to obtain those final payment amounts. The D.C. Circuit Court in *Tampa General* held the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well. Furthermore, in challenging the Medicare Contractor's use of a stub-period cost report covering one time period, rather than a twelve-month cost report covering a different period, the Provider is challenging the "period selected by the Secretary" used in creating those estimates, which is also barred from review.

Likewise, with regard to the argument that the Medicare Contractor should have excluded FY 2011 from its UCC DSH payment calculation, rather than include a "zero" in the average, the Board finds that it does not have jurisdiction to review this. While the Provider is not challenging any "estimate" or "period" which was actually chosen by the Secretary to calculate its 2017 Uncompensated Care payments, but rather the Medicare Contractor's alleged deviation from CMS' stated policy for making the calculation, the District Court for the District of Columbia held in *Scranton* that such a challenge is still barred from review, succinctly stating that any argument "that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[37]

Accordingly, the Board dismisses Case No. 17-1149 and removes it from the Board's docket. The Board notes that its ruling is consistent with the D.C. Circuit's decision in *Tampa General*, *DCH v. Azar*, and *Ascension* and that these decisions are controlling precedent for the interpretation of 42 U.S.C. § 1395ww(r)(3) because the Providers could bring suit in the D.C. Circuit.[38] 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.

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[37] *Scranton* at 265.

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

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RE: ***Jurisdictional Decision in Whole***
Case Name: Dupont Hospital LLC (Prov. No. 15-0150)
FYE 3/31/2010
Case No. 20-0504

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal relating to the Provider's fiscal year ending March 31, 2010 ("FY 2010") in response to the MAC's filing of a jurisdictional challenge. The Board's decision is set forth below.

Background

On June 28, 2019, the Medicare Administrative Contractor ("MAC") issued the Notice of Correction of Program Reimbursement ("NCPR") related to the Provider's FY 2010 cost report. The NCPR was issued to implement the administrative resolution of Case No. 13-2455GC, which recognizes specific labor and delivery room days in the numerator and denominator of the DSH Medicaid fraction.[1]

On December 3, 2019, the Provider filed an appeal of that FY 2010 NCPR with the Board and the request included the following three issues:

Issue 1: Disproportionate Share Hospital (DSH) – SSI Percentage (Provider Specific)
Issue 2: DSH – SSI Percentage
Issue 3: DSH – Medicaid Eligible Days[2]

[1] *Id*.
[2] MAC's Jurisdictional Challenge, at 1 (Oct. 8, 2020).

On June 10, 2020, the Provider transferred Issue 2, DSH – SSI Percentage, to Group Case No. 18-1832GC, CHS CY 2010 DSH SSI Percentage CIRP Group.[3]

On October 8, 2020, the MAC filed a jurisdictional challenge over the Board's jurisdiction over the remaining issues, issues 1 and 3.[4]

MAC's Jurisdictional Challenge

For both issues, the MAC alleges that the NCPR from which this appeal is taken, the MAC did not revise the DSH SSI percentage or the specific Medicaid days under appeal. Therefore, the MAC argues that the issues must be dismissed.[5]

Alternatively, the MAC contends that Issue 1 should be dismissed because: 1) the portions of Issue 1 concerning SSI data accuracy and individuals who are eligible for SSI but did not receive SSI payment are duplicates of Issue 2, which was transferred to Case 18-1832GC; and 2) The Board lacks jurisdiction over the SSI realignment.

Regarding Issue 3, the MAC asserts it adjusted labor and delivery room days in the numerator and denominator of the Medicaid fraction in the NCPR, not the additional Medicaid days requested in this appeal. As they did not render a determination to exclude the disputed days for the NCPR dated June 28, 2019, the MAC contends this issue must be dismissed.

Provider's Response

The Provider did not file a response to the challenge. Board Rule 44.4.3 states: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. *Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record.*"[6]

Board's Analysis and Decision

The Code of Federal Regulations provides for an opportunity for a revised NPR. 42 C.F.R. § 405.1885 (2011) provides in relevant part:

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

[3] *Id*.
[4] *Id*.
[5] MAC's Jurisdictional Challenge, at 1 (Oct. 8, 2020).
[6] (Emphasis added.)

> that made the decision (as described in § 405.1885(c) of this subpart).

42 C.F.R. § 405.1889 (2011) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary 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 42 C.F.R. §§ 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.

Finally, 42 C.F.R. § 405.1835(a)(1) provides:

> 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)).

The Board finds that it does not have jurisdiction over all three issues appealed by the Provider from the revised NPR, as none of the issues were specifically adjusted in the Provider's revised NPR.

Issue 1 and Issue 2– DSH SSI Provider Specific and DSH – SSI Percentage

The adjustments proposed by the MAC (*i.e.*, adjustments 5 and 6) impact the Medicaid fraction. Specifically, the NCPR implements adjustments to include labor and delivery room days in the numerator and denominator of the Medicaid fraction. They do not impact the SSI percentage. Moreover, as the NCPR was issued solely as a result of an administrative resolution, it would not appear that the Provider would have any basis to be dissatisfied with the adjustment made to execute that administrative resolution. Accordingly, the Board does not have jurisdiction over the two SSI issues pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889 as referenced in 42 C.F.R. § 405.1835(a)(1).

Because the SSI percentage was not adjusted, the provider had failed to document that the two SSI issues were revised in the NCPR, as if required by 42 C.F.R. § 405.1889. Therefore, the Board dismisses both the DSH/SSI (Provider Specific) issue and the DSH SSI issue because the Provider had no right to appeal those issues under 42 C.F.R. § 405.1889 as referenced in 42 C.F.R. § 405.1835(a)(1).

Accordingly, the Board also revokes and denies the transfer of Issue 2 to Case No 18-1832GC. The Board directs the Provider to ensure that it is removed from any future Schedule of Providers for Case No. 18-1832GC.

Issue 3 – Medicaid Eligible Days

Issue 3 is hereby dismissed because the reopening and the NCPR only allow for appeal rights for the specific labor and delivery room days adjusted. The Provider has not appealed labor and delivery room days with this case. Moreover, as the NCPR was issued solely as a result of an administrative resolution, it would not appear that the Provider would have any basis to be dissatisfied with the adjustment made to execute that administrative resolution. The Board does not have jurisdiction pursuant to 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889. Therefore, the Board dismisses the Medicaid Eligible Days issue because the Provider had no right to appeal that issue under 42 C.F.R. § 405.1889 as referenced in 42 C.F.R. § 405.1835(a)(1).

*****

As there are no more issues pending in this case, the Board hereby closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

11/23/2021

X Clayton J. Nix

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

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

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

Elon Berk
Gurovich, Berk & Associates
15250 Ventura Blvd., Ste. 1220
Sherman Oaks, CA 91403

RE: ***Notice of Dismissal***
True Care Hospice, Inc. (Prov. No. 55-1608)
FYE 10/31/2016
Case No. 20-0897

Dear Mr. Berk:

On January 22, 2020, the Provider Reimbursement Review Board ("Board" or "PRRB") received the appeal request for True Care Hospice, Inc. ("Provider"); however, the appeal request failed to include a Letter of Representation in compliance with Board Rule 5.4. On February 4, 2020, the Board issued an Acknowledgement and Critical Due Dates Notice which set forth certain filing deadlines. First, the Provider was required to submit a Representation Letter pursuant to Board Rule 5.4 no later than February 19, 2020, confirming that Gurovich, Berk & Associates is authorized to act on their behalf (*i.e.*, had authorized Grurovich, Berk & Associates to file the appeal on their behalf and to represent them before the Board) in order to cure the filing defect in the appeal request. The Notice also set a Preliminary Position Paper deadline of September 18, 2020. To date, the Provider has not submitted the Representation Letter or the Preliminary Position Paper.

Board Rule 41.2 (Aug. 29, 2018) permits dismissal or closure of a case on the Board's own motion:

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned,
- upon failure of the provider or group to comply with Board procedures,
- 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.

Board Rule 5.4 outlines the requirements of a Representation Letter:

> A representation letter is required whether designating an external or internal representative. The letter designating the representative must be on the provider's letterhead and be signed by an authorizing official of the provider or parent organization. The letter must reflect the provider's

> name, number, and fiscal year under appeal. The letter must **not** be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised.
> The letter must contain the following contact information for the representative:
>
> • name,
> • organization,
> • address,
> • telephone number, and
> • email address.

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

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

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

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

Board Rule 5.2 addresses the Representative's responsibilities:

> The representative is responsible for ensuring his or her contact information is current with the Board, including a current email address and phone number. *The case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board* or the opposing party.
>
> Failure of a 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 representative will also not be considered cause for delay of any deadlines or proceedings

Based on the failure of the Provider's representative meet the filing requirements for a Board appeal and then failure comply with the Board set deadline to cure that defect by filing the required representation letter,[1] the Board hereby dismisses this case and removes it from its docket. The Representative filed an appeal, for which they provided no authorization to act on the Provider's behalf.

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

For the Board:

11/23/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc.

[1] The Board Alert 19 suspension of Board set deadlines is not applicable since the relevant deadline tolled prior to the issuance of Board Alert 19 and since the requisite Letter of Representation is a filing requirement for an appeal request. Indeed, the Board notes that the same organization filed an appeal request for True Care Hospice for FY 2017 to which the Board assigned Case No. 20-0898 and, similarly, failed to file the requisite proof of authorization and abandoned the appeal. The Board is concurrently dismissing Case No. 20-0898 for the same reasons here.

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

Elon Berk
Gurovich, Berk & Associates
15250 Ventura Blvd., Ste. 1220
Sherman Oaks, CA 91403

RE: ***Notice of Dismissal***
True Care Hospice, Inc. (Prov. No. 55-1608)
FYE 9/30/2017
Case No. 20-0898

Dear Mr. Berk:

On January, 22, 2020, the Provider Reimbursement Review Board ("Board" or "PRRB") received the appeal request for True Care Hospice, Inc. ("Provider"); however, the appeal request failed to include a Letter of Representation in compliance with Board Rule 5.4. On February 4, 2020, the Board issued an Acknowledgement and Critical Due Dates Notice which set forth certain filing deadlines. First, the Provider was required to submit a Representation Letter pursuant to Board Rule 5.4 no later than February 19, 2020, confirming that Gurovich, Berk & Associates is authorized to act on their behalf (*i.e.*, had authorized Grurovich, Berk & Associates to file the appeal on their behalf and to represent them before the Board) in order to cure the filing defect in the appeal request. The Notice also set a Preliminary Position Paper deadline of September 18, 2020. To date, the Provider has not submitted the Representation Letter or the Preliminary Position Paper.

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- 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,
- if the Board is unable to contact the provider or representative at the last known address, or
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> *A representation letter is required whether designating an external or internal representative*. The letter designating the representative must be on the provider's letterhead and be signed by an authorizing official of the provider or parent organization. The letter must reflect the provider's

> name, number, and fiscal year under appeal. The letter must **not** be issue specific unless it is for participation in a group appeal in which there is only one issue permitted to be raised.[1]
> The letter must contain the following contact information for the representative:
>
> • name,
> • organization,
> • address,
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The regulations governing position papers can be found at 42 C.F.R. § 405.1853:

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

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

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

[1] (Italics emphasis added.)

Board Rule 5.2 addresses the Representative's responsibilities:

> The representative is responsible for ensuring his or her contact information is current with the Board, including a current email address and phone number. *The case representative is also responsible for meeting the Board's deadlines and for timely responding to correspondence or requests from the Board* or the opposing party.
>
> Failure of a 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 representative will also not be considered cause for delay of any deadlines or proceedings

Based on the failure of the Provider's representative meet the filing requirements for a Board appeal and then failure comply with the Board set deadline to cure that defect by filing the required representation letter,[2] the Board hereby dismisses this case and removes it from its docket. The Representative filed an appeal, for which they failed to provide the requisite proof of authorization to act on the Provider's behalf.

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
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For the Board:

11/23/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Pamela VanArsdale, National Government Services, Inc.

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