DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Denial of Request for Reconsideration***
CY 2008 DSH SSI Fraction Dual Eligible Days Group III
Case No. 18-0336G

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the Providers' October 6, 2020 Request for Reconsideration in the above-referenced appeal. The Board's decision ***denying*** that request is set forth below.

Background

The Providers in this group case filed an Expedited Judicial Review ("EJR") request over the SSI Dual Eligible Days issue on March 20, 2020. The issue was framed in the EJR request as follows:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not received an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

On September 23, 2021, the Board granted EJR over three providers, but dismissed one participant (appealing two fiscal years): University of Wisconsin Hospitals (Prov. No. 52-0090, FYEs 6/30/2007 and 6/30/2008). This provider was dismissed because it appealed a very non-specific DSH issue in its Requests for Hearing ("RFHs") that did not meet the specificity requirements set forth in 42 C.F.R. § 405.1835 and the Board's Rules. The Provider filed RFHs in August 2013 and included an issue for "Disproportionate Share SSI Percent" in Case Nos. 13-3155 and 13-3156:

[1] Providers' EJR Request at 2.

> Issue 1: Disproportionate Share SSI Percent
>
> Medicare Regulations at 42 CFR §412.106 address the computation of the SSI percentage used in the determination of a hospital's disproportionate patient percentage. During the FY07 field audit, the Intermediary improperly determined the Medicare DSH reimbursement by not permitting the Provider to obtain and reconcile the SSI data maintained by CMS with Provider records, as noted in adjustment #46 (attached). The provider believes this is incorrect, and is appealing this adjustment.[2]

The Board noted that between filing the RFHs (August 2013) and Final Position Papers ("FPPs") (January 31, 2017), the Provider changed its representative to Hall Render (November 28, 2016). The FPPs appeared to be the first place the dual eligible days issue and related legal authorities were mentioned, but the Board found that engaging a new representative did not allow the provider to transform the DSH/SSI issue that was actually appealed. Based on the record before it, the Board found that it had sufficient information in the record upon which to base a dismissal because the Provider's requests for hearing for FY 2007 and 2008 clearly did not meet the specificity requirements in 42 C.F.R. § 405.1835(a)-(b) to allow the Board to find that the SSI Duel Eligible Days was included within those requests for hearing.

On October 6, 2020, the Providers filed a Request for Reconsideration of these dismissals.

Provider's Position

The Provider ultimately asks the Board to reconsider its dismissal because, ***based on its interpretation of the procedural history of this group case and the individual cases from which it transferred***, "the [Medicare Contractor] and the Board had *adequate notice and opportunity* to consider the issue the Provider raised, and the issue was completely developed and presented to the Board before the Provider's claims were transferred to the group appeal."[3]

The Provider notes that, in October 2016, the Board issued Hearing Notices and Critical Due Dates Letters combining five individual appeals, including the Provider's two FYs under reconsideration (Case Nos. 13-3155 and 13-3156). Pursuant to these notices, the Provider filed a combined position paper on January 30, 2017, and the Medicare Contractor filed its FPPs on February 28, 2017. Thereafter the Provider alleges that a Board hearing was held, but the parties stipulated to a hearing on the record with respect to the Provider's two FYs under reconsideration (Case Nos. 13-3155 and 13-3156).[4] The parties later submitted Stipulations and an official request for record hearing which stipulated that the issue was:

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[2] Individual Appeal Request, Tab 3 (Case No. 13-3155). The issue statement for Case No. 13-3156 is identical except it concerns FY08 and audit adjustment #50.
[3] Request for Reconsideration of Dismissal of Claims at 3 (Oct. 6, 2021).
[4] *Id.* at 2; Exhibit C.

> Whether the Provider's Medicare Disproportionate Share Hospital ("DSH") reimbursement calculation was understated due to the Centers for Medicare and Medicaid Services ("CMS" or "Agency") and the Medicare Contractor not including all patient days for patients who were eligible for and enrolled in the SSI program but may not have received an SSI payment for the month in which they received services from the Provider ("SSI Eligible days") in the numerator of the Medicare Fraction of the DSH percentage. [5]

The parties also stipulated that the issue in both cases was identical to the issue presented in 13-1862GC, *et al*. (PRRB Dec. No. 2017-D11).[6]

On May 8, 2018, the Board issued a notice that it was considering EJR on its own motion for the two FYs under reconsideration (Cases Nos. 13-3155 and 13-3156),[7] which prompted the Providers to request a transfer of those individual appeals into the instant group case shortly thereafter, which the Board granted.[8]

The Provider argues that, based on this *procedural* history, the DSH claims were fully developed and the Medicare Contractor availed itself of the opportunity to respond to the Provider's combined final position paper, which included a full explanation of the DSH issue, prior to the hearing the Board conducted in May 2017. The Medicare Contractor also agreed to the issue as stated by the Provider and never objected to the Board's jurisdiction over the DSH issue.

The Provider argues that this *procedural* route was suggested by the Board, specifically stating:

> The Board ultimately determined that the matter was appropriate for expedited judicial review, and the Provider agreed to the Board's suggestion and requested a transfer into a Group Appeal for that purpose. It is important to note that the Board's suggestion of expedited judicial review was premised upon the statement of the DSH issue that parties had briefed in their final position papers and had stipulated was the issue to be decided at the time of the May 2017 hearing.[9]

Since the issue was fully developed and the Medicare Contractor had a chance to consider and respond to the issue, the Provider asks the Board to reconsider its dismissal.

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[5] Exhibit D.
[6] *Id*.
[7] Exhibit E.
[8] Exhibit G.
[9] Request for Reconsideration of Dismissal of Claims at 3.

Decision of the Board

The Board generally has the authority to reopen and revise its decisions.[10] In the instant case, the Board permitted transfers of a number of cases at the request of the parties, but did not conduct a complete jurisdictional review over these cases and their participants until the subject request for EJR was processed. The regulation at 42 C.F.R. § 405.1840 addresses Board jurisdiction and states in pertinent part:

> (a) *General rules*. (1) After a request for a Board hearing is filed under § 405.1835 or § 405.1837 of this part, the Board must determine in accordance with paragraph (b) of this section, whether or not it has jurisdiction to grant a hearing on each of the specific matters at issue in the hearing request.
>
> (2) The Board must make a **preliminary** determination of the scope of its jurisdiction (that is, whether the request for hearing was **timely**, and whether the **amount in controversy** requirement has been met), if any, over the matters at issue in the appeal **before conducting any of the following proceedings**:
>
> (i) **Determining its authority to decide a legal question relevant to a matter at issue (as described in § 405.1842 of this subpart)**.
>
> (ii) Permitting discovery (as described in § 405.1853 of this subpart).
>
> (iii) Issuing a subpoena (as described in § 405.1857 of this subpart).
>
> (iv) **Conducting a hearing** (as described in § 405.1845 of this subpart).
>
> (3) **The Board may revise a preliminary determination of jurisdiction at any subsequent stage of the proceedings in a Board appeal**, and must promptly notify the parties of any revised determination. . . .
>
> (5) **Final** jurisdictional findings and dismissal decisions by the Board **under paragraphs (c)(1)** and (c)(2) of this section are subject to Administrator and judicial review in accordance with paragraph (d) of this section.
>
> (b) *Criteria*. Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting

[10] 42 C.F.R. §§ 405.1885, 1887.

> period under appeal. **The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837[11] of this subpart, as applicable**. . . .
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. (1) **In issuing an EJR decision** under § 405.1842 of this subpart **or a hearing decision** under § 405.1871 of this subpart, as applicable, **the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue** in each contractor or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.[12]

Similarly, Board Rule 4 address Board Jurisdiction/Appealing Issues and provides the following general requirements at Board Rule 4.1 (Aug. 2018):

> **4.1 General Requirements**
>
> *See* 42 C.F.R. §§ 405.1835 - 405.1840.
>
> Appeals that fail to meet the timely filing requirements or jurisdictional requirements will be dismissed. A jurisdictional challenge may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements.[13]

With regard to jurisdiction, the Board notes that Board Rule 20 addresses the procedures for Schedules of Provider ("SoPs") and the associated supporting jurisdictional documentation in group appeals. Board Rule 20.1 addresses the filing requirements for SoPs:

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[11] 42 C.F.R. § 405.1837(a) states in pertinent part:
> (a) *Right to Board hearing as part of a group appeal: Criteria.* **A provider** . . . **has a right to a Board hearing**, as part of a group appeal with other providers, with respect to a final contractor . . . determination for the provider's cost reporting period, **only if** -
> (1) **The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c)**, except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).
> (2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
> (3) The amount in controversy is, in the aggregate, $50,000 or more . . . .

[12] (Bold and underline emphasis added.)

[13] (Underline emphasis added.)

> **20.1 Filing Requirements**
>
> Within 60 days of the full formation of the group (*see* Rule 19), the group representative must prepare a schedule of providers (Model Form G at Appendix G) and supporting jurisdictional documentation that demonstrates that the Board has jurisdiction over the providers named in the group appeal (*see* Rule 21).[14]

The content of the SoP is specified in Board Rule 21:

> **Rule 21 Group Schedule of Providers and Supporting Documentation – Content**
>
> The schedule of providers *must include all providers* in the group *and provide the associated documentation to support jurisdiction of the participating providers*. The schedule has two parts, a summary page with columns A-G and supporting documentation under the corresponding tabs A-G.[15]

Whether the Board has conducted a hearing does not in and of itself constrain subsequent review of jurisdiction by the Board as demonstrated by 42 C.F.R. § 405.1840 and Board Rule 4.1. In this regard, the Board notes that § 405.1840(a)(3) specifies that the Board "may ***revise*** a preliminary determination of jurisdiction at ***any*** subsequent *stage of the proceedings* in a Board appeal."[16] Regardless of whether the parties had proceeded to a hearing on the record, or a live hearing, the Board would have reviewed jurisdiction for the Provider and, prior to issuing a written final decision on the merits, found that: (1) the initial issue statements included in the appeal requests at issue were, *in and of themselves*, deficient and failed to comply with 42 C.F.R. § 405.1835(a)-(b); and (2) as a result, the Board lacked jurisdiction because the Provider did not have a right to a Board hearing under 42 C.F.R. § 405.1835 (as also referenced in § 405.1837(a)) for the issue that underlies the EJR request. Indeed, the Board may review jurisdiction on its own motion *at any time*[17] and is *required* to make a ***final*** jurisdictional decision prior to granting EJR.[18] To this end, the Board provides a process using SoPs (*see* Board Rules 20 and 21 above) in which the Group Representative must present, for purposes of Board review, the relevant documentation establishing the Board's jurisdiction for each participant.[19] Regardless of what

[14] (Underline emphasis added.)
[15] (Underline and italics emphasis added.)
[16] (Emphasis added.)
[17] Board Rule 4.4 (2015); Board Rule 4.1 (2018).
[18] 42 C.F.R. § 405.1840. *See also* Board Rue 42.1 ("Board jurisdiction must be established *prior to* grant and EJR request. . . . The Board will make an EJR determination within 30 days *after it determines that it has jurisdiction* and the request for EJR is complete. *See* 42 C.F.R. § 405.1842." (emphasis added)).
[19] *See also* Board Rule 42.3 (addressing the content of the EJR request and stating: "For a group appeal, the schedule of providers and supporting jurisdictional documents for each provider must also be filed in accordance with Rules 20 and 21. If the jurisdictional documents are not tabbed and formatted in accordance with the Board's instructions, the Board will return them to the group representative for correction before considering the EJR request.").

the parties may have stipulated in another case, they cannot waive jurisdictional requirements for any participants in a group appeal,[20] and moreover, the Provider has not supplemented the record in Case No. 18-0336G with any prior written jurisdictional findings by the Board on the Provider (whether pre- or post- transfer but which, again, would have necessarily been only *preliminary* pursuant to 42 C.F.R. § 405.1840).[21, 22] In summary, the Provider's Request for Reconsideration has presented primarily *procedural* arguments that are clearly refuted by 42 C.F.R. § 405.1840 and the Board Rules and, significantly, it does not otherwise question or challenge the EJR Determination's finding that the Provider's requests for hearing for FYs 2007 and 2008 did not meet the specificity requirements in 42 C.F.R. § 405.1835(a)-(b).

For the foregoing reasons, the Board hereby ***denies*** the Provider's Request for Reconsideration and declines to exercise its discretion to reopen or revise its September 23, 2021 EJR Determination.

Board Members Participating:

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

FOR THE BOARD:

12/2/2021

X Clayton J. Nix

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

cc: Wilson Leong, Esq., CPA, FSS
Pam VanArsdale, National Government Services, Inc. (J-6)

[20] Board Rule 4.4 (2015); Board Rule 4.1 (2018). The Board's acceptance of Stipulations (or any other piece of evidence) into the record for a case does not mean that the Board has otherwise accepted the factual and legal assertions therein as true and correct (including any stipulations regarding jurisdiction). Indeed, the parties themselves cannot waive jurisdictional requirements.

[21] To the extent the Board had issued prior written preliminary jurisdictional findings on the Provider, the Board would have considered and reviewed them prior to issuing its final jurisdictional decision on the Provider and revised them, as appropriate, pursuant to its authority under 42 C.F.R. 405.1840(a)(3). However, the Board has not identified any and the Provider not presented any. In this regard, the Board notes that the Board's transfer letter dated June 14, 2018, as included at Exhibit G, does not make any jurisdictional findings but rather grants the Provider's June 5, 2018 transfer request from the individual appeal to a group appeal. Similarly, the consolidated hearing transcript excerpt relating to certain individual appeals by the Provider, as included at Exhibit C, does not include any jurisdictional findings. Similarly, the fact that the Board had issued notice of a potential own motion EJR in reliance on the Provider's representation of the issue appealed in its final position paper (as discussed at p. 3 of the request for reconsideration and a copy of which is included at Exhibit E) is not a finding of jurisdiction because any findings of jurisdiction would necessarily be made as part of any actual EJR determination. Finally, to the extent the Provider is suggesting that certain prior Board actions (whether in these exhibits or elsewhere) implicitly included jurisdictional findings, they would have been, at best, only *preliminary* under the operation of 42 C.F.R. § 405.1840.

[22] Per Board Rule 47.1, a request for reinstatement must set forth the reasons for reinstatement.

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Via Electronic Delivery

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RE: ***Expedited Judicial Review Determination***
Northshore LIJ 2000-2003 Part C Days CIRP Group
Case No. 16-0496GC

Dear Ms. Webster:

The above-referenced common issue related party ("CIRP") group appeal[1] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. The Centers for Medicare & Medicaid Services' ("CMS") Ruling CMS-1739-R ("CMS Ruling 1739-R" or "Ruling") addresses how the Provider Reimbursement Review Board ("Board" or "PRRB") must treat provider appeals of the Medicare Part C Days issue. Under the terms of the Ruling, the Board must remand this issue to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

On November 17, 2021, the Group Representative confirmed that the subject CIRP group is fully formed.[2] Concurrently, on November 17, 2021, the Group Representative filed a request for Expedited Judicial Review ("EJR") of the Part C Days issue for the Providers in the above-referenced CIRP group appeal. The EJR request asks the Board to grant EJR despite the issuance of CMS Ruling 1739-R, and further challenges said Ruling.[3] The Board's decision to bifurcate the Provider's EJR Request, and to grant EJR in part and deny it in part, is set forth below.

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

Statutory and Regulatory Background

Medicare Advantage Program

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

In the September 4, 1990 Federal Register, the Secretary[4] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[5]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[6]

With the creation of Medicare Part C in 1997,[7] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under

[4] of Health and Human Services.
[5] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[6] *Id.*
[7] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-

Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[8]

No further guidance regarding the treatment of Part C days in the DSH calculation was provided until the 2004 Inpatient Prospective Payment System ("IPPS") proposed rules were published in the Federal Register. In that notice, the Secretary stated that:

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction* . . . .[9]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[10] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[11]

This statement would require inclusion of Medicare Part C inpatient days in the Medicare fraction of the DSH calculation.

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173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[8] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[9] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[10] 69 Fed. Reg. at 49099.

[11] *Id.* (emphasis added).

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[12] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[13] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[14]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[15] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[16] In *Allina Health Services v. Price* ("*Allina II*")*,*[17] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[18] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[19] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[20]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare

[12] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[13] *Id*. at 47411.
[14] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[15] 746 F. 3d 1102 (D.C. Cir. 2014).
[16] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[17] 863 F.3d 937 (D.C. Cir. 2017).
[18] *Id.* at 943.
[19] Id. at 943-945.
[20] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).

Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[21] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[22] The Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[23]

Regarding EJRs for this Issue, and the fate of these appeals, the ruling notes, specifically, that:

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court

[21] CMS Ruling 1739-R (Aug. 17, 2020).
[22] *Id*.
[23] *Id*.

> precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[24]

Providers' Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal year 2000-2003 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[25] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[26] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[27] As such, the Providers conclude that the Board is "required" to grant EJR.[28]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[29] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[30]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here….[31]

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[24] CMS Ruling 1739-R at 6-7.
[25] Providers' Petition for Expedited Judicial Review, at 1 (Nov. 17, 2021).
[26] *Id*. at 1.
[27] *Id*.
[28] *Id*. at 1-2.
[29] *Id*. at 11-12.
[30] *Id*. at 21.
[31] *Id*. at 13-14.

> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz,* 536 U.S. 622, 627 (2002)).[32]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[33]

Board's Analysis and Decision

After review of the Providers' EJR Request, the Board has determined that it contains two separate and distinct issues for the Board to consider.

The first issue is Providers' challenge to the inclusion of Medicare Part C days in the Medicare fraction of the DSH percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, as explained *supra*. This first issue is the ***substantive issue*** upon which the Providers established the CIRP group and the source of the Providers' dissatisfaction.

The second issue is a challenge to the validity of the mandate within CMS Ruling 1739-R that divests the Board of ***substantive jurisdiction*** over the Medicare Part C Days issue that, *but for the Ruling*, the Board would have jurisdiction to consider. This second issue arose when CMS issued CMS Ruling 1739-R on August 17, 2020 (well after these CIRP groups were established).

[32] *Id*. at 14.
[33] *Id*. at 17.

Board's Authority

The Board's authority to consider a provider's EJR request is contained within 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2019). Under its statutory and regulatory authority, the Board is required to grant a provider's EJR request if it determines that (1) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (2) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Board's analysis is detailed below.

Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. 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 for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[34, 35]

The Providers included in the instant EJR request filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending from 12/31/2000 and 12/31/2003.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen* ("*Bethesda*").[36] 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.[37]

The Board has determined that the participants' appeals involved with the instant own-motion EJR are governed by the decision in *Bethesda*. The Providers appealed from original NPRs. In

[34] 42 C.F.R. § 405.1835(a).
[35] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[36] 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.).
[37] *Bethesda*, 108 S. Ct. at 1258-59.

addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[38] and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount. Accordingly, the Board finds that it has jurisdiction for the referenced appeal and the participants.

Medicare Part C Days Issue

Under 42 C.F.R. § 405.1867, the Board must comply with the provisions of Title XVIII of the Act and regulations issued thereunder, *as well as CMS Rulings issued under the authority of the Administrator*.[39] As set out within CMS Ruling 1739-R, the Administrator mandates that the Board now "lack[s] jurisdiction over certain provider appeals regarding the treatment of days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentages[,]"[40] *i.e.*, the Part C Days issue. Specifically, CMS Ruling 1739-R applies "to appeals regarding patient days with discharge dates *before* October 1, 2013[,] that arise from [NPRs] that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates *before* October 1, 2013[,] or that arise from an appeal based on an untimely NPR . . . and any subsequently issued NPR for that fiscal year pre-dates the new final rule."[41] To date, CMS has yet to issue its new final rule.[42]

As the Providers' appeals concern the FY 2000-2003 cost reporting periods, CMS Ruling 1739-R confirms that the Board lacks substantive jurisdiction over the providers' Part C Days issue *as of August 17, 2020* (*i.e.*, the date CMS Ruling 1739-R was issued). Under 42 C.F.R. § 405.1842(f)(2)(i), the Board *must* deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if the Board determines that it lacks jurisdiction to conduct a hearing on the specific matter. Thus, the Board must deny providers' EJR request concerning the Medicare Part C Days issue.

CMS Ruling 1739-R also "requires that the [Board] remand any otherwise *jurisdictionally proper* challenge raising this issue to the appropriate Medicare contractor."[43] Accordingly, the Board will issue, under separate cover, a remand for the group appeal providers with a "qualifying" appeal determined to be "jurisdictionally proper" (*i.e.*, determine if they are ripe for remand under 1739-R) pursuant to the mandates set out in the Ruling.

Validity of CMS Ruling 1739-R

Within the EJR Request, the Providers also challenge the validity of CMS Ruling 1739-R, stating:

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[38] *See* 42 C.F.R. § 405.1837.
[39] (Emphasis added.)
[40] CMS Ruling 1739-R at 1-2.
[41] Id. at 2.
[42] CMS issued its proposed rule, CMS 1739-P, on August 6, 2020. *See* 85 Fed. Reg. 47723 (Aug. 6, 2020).
[43] (Emphasis added.)

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[44]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[45] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[46]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. Nonetheless, the Board questions whether a provider's claim that

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[44] EJR Request at 17.

[45] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

[46] *See Southwest* at 6-7.

CMS has improperly treated Medicare Part C Days in the DSH calculation may be considered moot simply by "the Ruling's mere declaration" [47] that it is so and, as such, serve as the basis to divest the Board of ***substantive*** jurisdiction over the claim.[48]

As noted prior, the Board must grant EJR 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.[49] Here, the Providers essentially challenge the Board's *application* of the CMS Ruling 1739-R. Specifically, the Providers challenge the validity of the mandate within the Ruling that purports to divest the Board of *substantive* jurisdiction over the Medicare Part C Days issue that, but for the Ruling, the Board has the authority to consider. The Board finds that it has jurisdiction over this challenge since it goes to the Board's application of the Ruling, ***but*** lacks the authority to decide the challenge because 42 C.F.R. § 405.1867 specifies that the Board must comply with such Rulings.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of all providers within the instant group appeals;

2) The Board hereby **denies** Providers' EJR Requests regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to CMS 1739-R, the Providers will receive remand letters of this issue under separate cover; and

3) The Board hereby **grants** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877 upon final disposition of the appeal.

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[47] *See Southwest* at 10. For brevity sake, the Board hereby incorporates by reference the detailed discussion regarding "mootness" contained within *Southwest* into the instant EJR determination.
[48] *See* CMS 1739-R at 8.
[49] 42 U.S.C. § 1395oo(f)(1); 42 C.F.R. § 405.1842(f)(1).

Board Members Participating:

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For the Board:

12/3/2021

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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RE: ***EJR Determination***
Penn State Health Milton S. Hershey Medical Center (Prov. No. 39-0256)
FYE 6/30/2018
Case No. 22-0090

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 23, 2021 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

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

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

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

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

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

The Medicare Statute

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as

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

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

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

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

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

[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).

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

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

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

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

> Add the two products to determine the hospital's reduced cap.[12]

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

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

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

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

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

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

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.

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

The Providers' Position

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

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[19] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[20] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Provider contends that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[21]

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

Third, in some situations, as demonstrated by the Table on page 11 of the Provider's EJR Request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

The Provider concludes that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since the Board lacks the authority to grant the relief sought, the Provider requests that EJR be granted.
The Medicare Contractor has not filed a response to the EJR Request and the time for doing so has elapsed.[22]

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[17] Provider's Petition for Expedited Judicial Review at 1 (Nov. 23, 2021) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[18] *Id.* at 8.
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[21] *Id.* at § 1395(h)(4)(F)(i).
[22] PRRB Rule 42.4 (2021).

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2019), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Compliance with requirements for filing a Board appeal

The Provider submitted its individual appeal on November 1, 2021 from the Notice of Program Reimbursement dated May 5, 2021. Additionally, the Provider's stated amount in controversy exceeds the $10,000 threshold. Finally, the Board has jurisdiction over the substance of the appealed issue (*i.e.*, administrative review of the appealed issue is not precluded by statute or regulation).

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The Provider appealed from a cost reporting period beginning on or after January 1, 2016, and is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[23] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[24]

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"[25] with the reimbursement requirement of an appropriate cost report

[23] 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").
[24] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[25] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

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.[26] In this case, the Provider filed its EJR request on November 23, 2021 and, under Board Rule 44.5.1 (effective November 1, 2021), the Medicare Contractor had five (5) days from that filing failed to submit a Substantive Claim Challenge but failed to do so within that time frame.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[27] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis of the Appealed Issue

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

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [28]

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.[29] 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

[26] *See* 42 C.F.R. § 405.1873(a).
[27] 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."
[28] EJR Request at 4.
[29] *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.)).

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.[30] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

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

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.[32] 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."[33] 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[34] (*i.e.*, ratios) using variables a, b, c, and d:

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

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[30] 66 Fed. Reg. at 39894 (emphasis added).
[31] (Emphasis added.)
[32] *See* 62 Fed. Reg. at 46005 (emphasis added).
[33] *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.)).
[34] 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.

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.[35]

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.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

[35] 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.

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(ii)-(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the case, the Board hereby closes the case. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

12/9/2021

X Clayton J. Nix

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Mail

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RE: ***EJR Determination***
Northwestern Memorial Hospital (Prov. No. 14-0281)
FYE 8/31/2019
Case No. 21-1525

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' November 23, 2021 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

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

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

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

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

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

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The Providers' Position

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

The Provider claims that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[19] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[20] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Provider contends that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[21]

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

Third, in some situations, as demonstrated by the Table on page 11 of the Provider's EJR Request, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Provider points out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.

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

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[17] Provider's Petition for Expedited Judicial Review at 1 (Nov. 23, 2021) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[18] *Id.* at 8.
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[21] *Id.* at § 1395(h)(4)(F)(i).

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

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2019), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Compliance with requirements for filing a Board appeal and Jursidiction

The Provider in this case filed based on the MAC's failure to issue a timely final determination. The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[23]

In this case, the Provider filed a timely appeal. Its amount in controversy also exceeds the $10,000 threshold. The Provider also filed an appeal of the DGME issue before the 12 month period after the date of the receipt of the cost report by the Medicare Contractor and Board review of the DGME issue is not precluded by statute or regulation. Accordingly, the Board concludes that it has jurisdiction over the DGME issue.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The Provider appealed from a cost reporting period beginning on or after January 1, 2016, and is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost

[22] PRRB Rule 42.4 (2021).
[23] (emphasis added).

report claim.[24] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[25]

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"[26] 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.[27] In this case, the Provider filed its EJR request on November 23, 2021 and, under Board Rule 44.5.1 (effective November 1, 2021), the Medicare Contractor had five (5) days from that filing failed to submit a Substantive Claim Challenge but failed to do so within that time frame.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[28] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

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[24] 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").
[25] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[26] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[27] *See* 42 C.F.R. § 405.1873(a).
[28] 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."

C. Board's Analysis of the Appealed Issue

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

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}\,[29]$$

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.[30] 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.[31] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted

[29] EJR Request at 4.
[30] *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.)).
[31] 66 Fed. Reg. at 39894 (emphasis added).

> FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[32]

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.[33] 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."[34] 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[35] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[36]

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

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[32] (Emphasis added.)
[33] *See* 62 Fed. Reg. at 46005 (emphasis added).
[34] *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.)).
[35] 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.
[36] Note that, in using equivalent ratios, the key is the relationship of the ratios. As such, the relation between the ratios does not change if they are flipped. For example, if these ratios are flipped, then the initial equation becomes the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

value of the weighted FTEs being reduced in the same proportion as the FY Unweighted FTE Count exceeds the Unweighted FTE cap. The full proportional equation is expressed as follows:

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

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

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

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

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the case, the Board hereby closes the case. The Board's jurisdictional

determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

12/14/2021

X Clayton J. Nix

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

cc: Pamela VanArsdale, National Government Services, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Mayo Clinic CY 2016 DSH SSI Dual Eligible Days Group
Case No. 20-1341GC

Dear Ms. Griffin:

Relative to the above-captioned common issue related party ("CIRP") group, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 23, 2021 request for expedited judicial review ("EJR") and the comments submitted to the Board's October, 27 2021 Notice of Own Motion EJR relative to 42 C.F.R. §§ 413.24(j) and 405.1873. By way of background, on July 22, 2021, subsequent to the EJR filing for the above-referenced CIRP group appeal, the Board issued a Scheduling Order for the briefing of jurisdiction as well as setting deadlines for the filing of any substantive claim challenges made pursuant to 42 C.F.R. § 405.1873(a). The parties filed responses on August 20, 2021 and September 29, 2021.

Upon review of the parties responses, the Board issued a notice on October 27, 2021 of a potential own motion EJR based on arguments raised in the Providers' response to the Medicare Contractor's Substantive Claim Challenge filed on August 20, 2021 and ordered the parties to file comments on the Board's notice by November 27, 2021. The Board further noted that the notice and the parties' comment on that notice would serve to augment the Providers' original pending EJR request filed on June 23, 2021. Comments to the own motion EJR were filed on November 24, 2021 and Noveber 29, 2021. The Board decision with respect to the Providers' request for EJR and the Board's own motion EJR determination are set forth below.

Issues for EJR:

A. The Providers' Request for EJR

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

> The days at issue in th[is] appeal[] are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in th[is] appeal[] is whether the intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction"

> for purposes of calculating the Provider's [Disproportionate Share Hospital] DSH payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction, CMS [the Centers for Medicare & Medicaid Services] is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish the Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[1]

B. Board's Notice of Proposed Notice of Own Motion EJR

The issues for which the Board is considering for own motion EJR relate to the Providers' challenge to the substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873 which as found in their substantive cost report brief. In their response to the Medicare Administrative Contractor's (MAC's) substantive claim challenge, the Providers' representative challenged the substantive validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873, and did not appear to present any evidence that they complied with regulations requiring providers a specific claim for an item that it is self-disallowing.[2]

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[1] EJR Request at 2-3 (emphasis added).

[2] *See* 42 C.F.R. § 413.24(j)(2) (in order to properly self-disallow a specific item an estimated amount for each specific self-disallowed item must be on the protest line(s) of the providers cost report). 405.1873(a) (in order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item. . . .the Board must address [whether the cost report included a specific claim for an item]).

Statutory and Regulatory Background:

A. Background on the Medicare Disproportionate Share Hospital ("DSH") Payment

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)
[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).

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

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

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

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

1. The individual fails to give the SSA permission to contact financial institutions;[16]
2. The individual fails to apply for other benefits to which the individual may be entitled;[17]
3. The individual fails to participate in drug or alcohol addiction treatment;[18]

[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.

4. The individuals is absent from the United States for more than 30 days;[19] or
5. The individual becomes a resident of a public institutions or prison.[20]

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

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

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

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[19] 20 C.F.R. § 416.215.
[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a

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

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

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and

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month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

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

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

(2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

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

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[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.

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

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

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

1. Background for Payments and Cost Reporting Requirements

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

Under IPPS, providers are generally paid for each patient discharge after a bill is submitted. The statute, 42 US.C. §§ 1395g(a) and 1395l(e), provide that no payments will be made to a provider

[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[43] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[44] *Id.* at *70555*.
[45] *Id.* at 70551.
[46] *Id.* at 70552.

unless it has furnished the information, requested by the Secretary needed to determine the amount of payments due the provider under the Medicare program. In general providers submit this information through annual cost reports that cover a 12-month period of time. All providers participating in the Medicare program are required under 42 C.F.R. § 413.20(a) to maintain sufficient financial records and statistical data for proper determination of costs. Moreover, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the hospital and related fields. Under the provisions of 42 C.F.R. §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year.[47]

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

Until 1988, when the Supreme Court issued its decision in *Bethesda Hospital v. Bowen* ("*Bethesda*"),[48] the Secretary did not allow providers to "self-disallow" a claim for reimbursement. A self-disallowance occurs were the provider submits a cost report that complies with Medicare policy for an item and then appeals an item to the Board that was ***not*** *included in its cost report.* In this situations, the MAC's NPR does not include a disallowance or adjusgment for that item. In *Bethesda*, the U.S. Supreme Court held that despite the providers failure to claim all of the reimbursement they believed should have been made, the plain language of the dissatisfaction requirement in 42 U.S.C. § 1395oo(a)(1)(A) supported Board jurisdiction because the MAC had no authority to award reimbursement in excess of a regulation by which it was bound. Consequently, it would have been futile for the providers to try to persuade the MAC otherwise. The U.S. Supreme Court also stated in *dicta*, that the dissatisfaction requirement might ***not*** be met if providers were to ''bypass a clearly prescribed exhaustion requirement or . . . fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules''[49, 50]

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

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[47] *Id.* at 70552-3.
[48] 485 U.S. 399 (1988).
[49] *Id.* at 404-405.
[50] 80 Fed. Reg. at 70554.
[51] *See generally,* 73 Fed. Reg. 30190 (May 23, 2008). (Provider Reimbursement and Appeals Final Rule).
[52] *Id. at* 30195-30200.
[53] 80 Fed. Reg. at 70557.

Subsequently, in 2015, this regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[54] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The U.S. District Court for D.C. concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[55]

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

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

Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this Ruling, "[i]f the PRRB . . . determines that the specific item under appeal was subject to a regulation or other payment policy that bound the Medicare contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, then the pertinent reviewing entity shall not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable), to the specific non-allowable item under appeal; instead, the reviewing entity should apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures."[57]

Prior to CMS Ruling 1727-R and concurrent, with the *Banner* litigation, the Secretary promulgated new cost reportinging regulations. Specifically, as part of the November 13, 2015 Final Outpatient Prospective Payment Rule,[58] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim effective for cost reporting period beginning on or after Jauary 1, 2016.[59] The Secretary

[54] 201 F. Supp. 3d 131 (D.D.C. 2016).
[55] *Id.* at 142.
[56] CMS Ruling 1727-R at 5.
[57] *Id*. at 7.
[58] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[59] These regulations were effective for cost reporting periods beginning on or after January 1, 2016 (See 80 Fed. Reg. 70298).

determined that the requirement that a provider either claim reimbursement for a specific cost, or expressly self-disallow the cost, in its cost report is more appropriately treated as a cost reporting requirement under 42 U.S.C. §§ 1395g and 1395l, as the Secretary cannot make payments to a provider without sufficient information on all claims for which the provider believes it should be paid.[60] To that end, the Secretary added a new paragraph (j) to 42 C.F.R. § 413.24. Paragraph (j)(1) of § 413.24 provides that, in order to receive or potentially qualify for payment for a specific item, the provider must include *on its cost report* an appropriate claim for the specific item. *In order to make an appropriate claim for an item* ***on its cost report***, the provider must either claim payment for the item in its cost report where it is seeking payment that it believes is consistent with Medicare policy, or self-disallow the item on the cost report if the provider is seeking payment that it believes may not comport with Medicare policy (for example, where the MAC does not have the authority or discretion to award the payment sought by the provider). In order to properly self-disallow a specific item on the cost report, the provider would have to follow the applicable procedures for filing a cost report under protest.[61]

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

> (1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—

[60] *Id*. at 70554.
[61] *Id*. at 70555.
[62] *Id*. at 70298.

> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether

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

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

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[64]

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

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[63] (Bold and underline emphasis added.)
[64] 75 Fed. Reg. at 50275-86.
[65] *Id.* at 50281.

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

Decision of the Board:

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

A. Jurisdiction

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

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[67] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

On July 22, 2021, the Board sent the parties a letter noting that in the case referenced above, one or more of the participants had cost reporting perioding beginning on or after January 1, 2017, and as a result the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. Both parties have responded to the Board's query as to the applicability of the regulations to the Providers in these

[66] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[67] (Emphasis added.)

cases. Neither party requested that the Board conduct an oral proceeding on the substantive claims challenges.[68]

1. MAC's Substantive Claim Challenge

The MAC does not believe that either of the Providers in this group appeal claimed reimbursement for the DSH SSI Ratio Dual Eligible days issue on their respective cost reports and none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply.

a. Mayo Clinic Health System-Franciscan Healthcare (Prov. No. 52-0004, FYE 12/31/2016)

The MAC asserts that there is nothing in the record to show where the Provider attempted to claim the disputed items for full reimbursement following a belief that the items comported with Medicare program policy. The MAC notes the Provider cites Audit Adjustment No. 11 as the basis for its dispute and that Audit Adjustment No. 11 removed Part A protested amounts totaling $111,545. However, the MAC asserts that this adjustment does not indicate that the Provider sought to claim full reimbursement for *the specific item in dispute* in accordance with Medicare policy. The MAC explains that the calculation support submitted by the Provider reflects and increase in the Medicaid ratio of the DSH calculation for Medicare Part C and Dual Eligible days, there is no evidence that the items self-disallowed by the Provider result in a change to the Medicare SSI fraction ratio. Therefore, the MAC contents that the Provider did not establish a self-disallowed item for the allegedly excluded DSH SSI Dual Eligible Days.

b. Mayo Clinic Health System-Eau Claire (Prov. No. 52-0070, FYE 12/31/2016)

The MAC asserts that there is nothing in the record to show where the Provider attempted to claim the disputed items for full reimbursement following the belief that the items comport with Medicare Program policy. The MAC notes that the Provider identifies Audit Adjustment No. 11 as the basis for the dispute and that Audit Adjustment No. 11 removed Part A Protested amounts totaling $218,689. However, the MAC asserts that this adjustment does not indicate that the Provider sought to claim full reimbursement for the issue in dispute. The MAC explains the calculation support submitted by the Provider reflects an increase in the Medicaid ratio of the DSH calculation for Medicare Part C and Dual Eligible days, there is no evidence that the items self-disallowed by the Provider resulted in a change in the Medicare SSI ratio. Therefore, the MAC contends that the Provider did not establish a self-disallowed item for the purportedly excluded DSH SSI Dual Eligible Days.

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

2. Providers' Response to the MAC's Substative Claim Challenge

In this case, the Representative does not refute the MAC's assertion that Mayo Clinic Health System-Franciscan Healthcare (Prov. No. 52-0004) or Mayo Clinic Health System-Franciscan Healthcare (Prov. No. 52-0004) did not protest the dual eligible days issue. Rather, they raise arguments, *discussed infra*, about why the regulations, 42 C.F.R. §§ 413.24(j) and 405.1873, are invalid/nonsensical.

The Providers assert that the MAC filed a substantive claim challenge indicating that the Providers are subject to the "substantial claim" requirements of 42 C.F.R. §§ 413.24(j) and 405.1873, effective with cost reporting periods beginning on or after January 1, 2016. However, the Providers note that, prior to the January 1, 2016 period, a nearly identical regulatory policies were stricken by the Federal courts in *Bethesda Hospital Association v. Bowen*[69] *(*"*Bethesda*") and *Banner Heart Hospital v. Burwell ("Banner").*[70] The Providers believe that, pursuant to 42 U.S.C. § 1395oo(a), they only need to be dissatisfied with the final determination of the MAC and meet the monetary threshold for Board jurisdiction.

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

The Providers notes that, when enacting the 2008 update to the Board's regulations at 42 C.F.R. § 405.1835(a)(1), the Secretary instituted the requirement that in order to preserve their appeal rights, providers must either claim a cost on their cost reports or file the matter under protest. In *Banner*, the D.C. District Court in *Banner* examined a challenge to the validity of this regulatory requirement. The Providers' assert that the D.C. District Court determined that satisfaction with a regulatory scheme cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the MAC and that the D.C. District Court found that submitting a regulatory challenges to the MAC was unnecessary and conflicted with the plain meaning of 42 U.S.C. § 1395oo. The Providers then assert that the Administrator[71] subsequently implemented CMS Ruling CMS-1727-R to eliminate the regulatory self-disallowance requirements prior to January 1, 2016.

Here, the Providers assert, the Board should disregard the 2016 regulation requiring administrative exhaustion (filing a cost report under protest) a prerequisite to payment. The Providers maintain where the issue under appeal is a regulatory challenge, the exhaustion requirement outlined in 42 C.F.R. §§ 413.24(j) and 405.1873 denies providers meaningful

[69] 485 U.S. 399, 400 (1988).
[70] 201 F.Supp. 3d 131, 133 (D.D.C. 2016).
[71] of the Centers for Medicare & Medicaid Services.

review, even if it does not bar jurisdiction. Further, the 2016 regulations violates the Providers statutory right to appeal under 42 U.S.C. § 1395oo(a) because a procedural finding that that payment for the Providers' claims was foreclosed voids the Board's jurisdiction.

3. Board Notice of Potential Own-Motion EJR

On September 1, 2021, the Board sent the parties a letter that contained: (1) a ruling on jurisdiction and the Medicare Contractor's substantive claim challenge; and (2) notice of a potential own motion EJR relative to 42 C.F.R. §§ 413.24(j) and 405.1873.

The Board issued the October 27, 2021 notice of potential Own Motion EJR to notify the parties that the Board is considering an own-motion EJR of certain questions that the Provider raised in its September 29, 2021 filing challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. The Board further informed the parties that the own motion EJR would, if issued, serve to augment the Provider's original pending EJR request filed on June 23, 2021 that is currently stayed per the Board's letters dated July 22, 2021 and October 27, 2021.[72]

Accordingly, the Board required the parties to file comments within 30 days (*i.e.*, by Friday, November 26, 2021) regarding whether a Board own motion EJR (pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842) is appropriate for the above questions raised by the Provider. The Provider timely filed comments on the Board's notice of potential EJR on Wednesday, November 24, 2021. In contrast, the MAC filed comments one day late on Monday, November 29, 2021.

The Providers have no objection to the Board's notice of potential own-motion EJR. In contrast, the MAC asserts that, to the extent the Provider now wishes to challenge 42 C.F.R. § 413.24(j), it should have and was required to do so as part of its appeal request. Accordingly, the MAC contends that the Board lacks jurisdiction over the Provider's challenge to §§ 413.24(j) and 405.1873 as the Providers' challenge to these regualtiosn was first raised in the Providers' response to the MAC's Substantive Caim Challenge. To the extent the Board finds that it does have jursdiciton over the challenge to 42 C.F.R. § 413.24(j), the MAC does not oppose the Board's notice of potential own-motion EJR.

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[73] may not be

[72] In this regard, the Board noted that, if the Board were to grant EJR: (1) pursuant to 42 C.F.R. § 405.1873(f) the Board's ruling on a substantive claim challenge impacts whether the provider will ultimately receive reimbursement; and (2) if the Board ultimately grants EJR in this case, 42 C.F.R. § 405.1873(d)(2) specifies that the Board must include its findings on any substantive claim challenge raised by a party, notwithstanding the questions raised by the Provider challenging the legal validity of that regulation.
[73] (Emphasis added.)

invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

a. Board Findings on Meeting Appropriate Cost Repor Claim Requirements

In this case, the Providers did not establish that they had filed the issue that is the subject of this appeal under protest. Indeed, the Providers in their response to the MAC's Substantive Claim Challenge conceded that they did not claim or protest the *additional* DSH reimbursement being sought due to the alleged *error* in the calculation of the SSI percentage and rather allege that, based on *Bethesda*, simply including a claim on the cost report for a DSH adjustment is enough. The arguments presented are simply reiterations of the Provider's challenge to the validity of 42 C.F.R. § 413.24(j) and § 405.1873 as discussed *infra*.

Contrary to the Providers' assertion, the Board is bound by and must apply § 413.24(j) and § 405.1873 as relevant. Here, it is clear from the record that the Mayo Clinic Health System-Lacross (Prov. No. 52-0004, FYE 12/31/16) and the Mayo Clinic Health System-Eau Claire (Prov. No. 52-0070, FYE 12/31/2016) did not comply with their obligation under § 413.424(j)(1) to "include an appropriate claim for the ***specific*** item"[74] by either: (1) "[c]laiming ***full*** reimbursement . . . for the specific item"[75] (*i.e.*, claiming the ***full*** reimbursement it believes it is due as a result of the alleged error in the SSI fraction as used in the DSH adjustment calculation); or (2) protesting the issue in this appeal following the procedures set forth in § 413.424(j)(2) "for properly disallowing the specific item in the provider's cost report as a protested amount." Here, the Providers failed to make a claim for the "specific item" (*i.e.*, claim reimbursement for the *additional* class of days that it alleges were improperly excluded from the SSI fraction) or protest the "specific item" (*i.e.*, protest the exclusion of the class of days at issue in this appeal from the SSI fraction). In this regard, the Providers only included on the cost reports at issue protested items for the inclusion of additional days *to the* ***Medicaid***

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

[75] (Emphasis added.)

fraction (as denoted by the reference to Worksheet S-2, Part-1, Line 24) and, as such, does not relate to the issue under appeal. The record is clear that the workpapers supporting the protested items do not include the issue for this appeal and none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply (in particular, there is no adjustment for the issue under appeal).

Based on the above, the Board finds that Mayo Clinic Health System-Franciscan Healthcare (Prov. No. 52-0004) or Mayo Clinic Health System-Franciscan Healthcare (Prov. No. 52-0004) did not specifically include a substantive claim for the group's DSH SSI Fraction Dual Eligible Days issue as required under 42 C.F.R. § 413.424(j).

b. Board Ruling on its Notice of Potential Own-Motion EJR

Contrary to the MAC's assertion, the Board finds that it has jurisdiction over the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 because the Board had jurisdiction over the issue being appealed (*i.e.*, the group's SSI entitlement/eligibility issue) and the Provider's challenge to those regulations is an outgrowth of that appeal and only became relevant as a defense to the MAC's Substantive Claim Challenged filed pursuant to 42 C.F.R. § 405.1873(a).
The Provider's challenge to §§ 413.24(j) and 405.1873 is substantive as demonstrated by the following allegations made by the Providers:

- "42 C.F.R. §§ 413.24(j) and 405.1873 violate the Providers' statutory right to a meaningful appeal under 42 U.S.C. § 1395oo(a), as already determined by *Bethesda*, *Banner*, and *Bayshore*."

- "The 2016 Regulation additionally violates each Provider's statutory right to an appeal under 42 U.S.C. § 1395oo(a) because a procedural finding that payment for the Providers' claims is foreclosed voids the Board's jurisdiction over the claims."

EJR of these issues is appropriate as there are no factual issues for Board resolution and the Board does not have the authority to declare these regulations invalid.

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

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[76] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[77]

[76] CMS Ruling 1498-R at 27.
[77] *Id.* at 31.

Contemporaneous with CMS Ruling 1498-R[78] the Secretary published a proposed IPPS rule[79] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[80]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[81]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[82]

The Secretary did not incorporate the above new policy involving the revised data match process into the Code of Federal Regulations. However, it is clear from the language in the final IPPS rule, as set forth above, that the Secretary intended to bind the regulated parties and establish a

[78] *Id.* at 5.
[79] 75 Fed. Reg. 23852, 24002-07.
[80] 75 Fed. Reg. at 50277.
[81] (Medicare) Enrollment Database.
[82] 75 Fed. Reg. at 50285.

binding data match process to be used by the Medicare Contractors in calculating (or recalculating) the SSI fractions for all hospitals pursuant to 42 C.F.R. § 412.106(b)(2).

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[83] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

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

D. Summary of the Board's Findings:

The Board makes the following findings:

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

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, there are no findings of fact for resolution by the Board;

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

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

   A. Whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid; and

   B. Whether 42 C.F.R. §§ 413.24(j) and 405.1873 are substantively valid.

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

Accordingly, the Board finds that the questions of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) and 42 C.F.R. §§ 413.24(j) and 405.1873 aproperly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

12/16/2021

X Clayton J. Nix

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

cc: Pamela VanArsdale, NGS
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RE: ***EJR Determination***
Hall Render CY 2017 DSH SSI Dual Eligible Days Group
Case No. 19-2599G

Dear Ms. Griffin:

Relative to the above-captioned common issue related party ("CIRP") group, the Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Providers' June 23, 2021 request for expedited judicial review ("EJR") and the comments submitted to the Board's October, 27 2021 Notice of Own Motion EJR relative to 42 C.F.R. §§ 413.24(j) and 405.1873. By way of background, on July 22, 2021, subsequent to the EJR filing for the above-referenced CIRP group appeal, the Board issued a Scheduling Order for the briefing of jurisdiction as well as setting deadlines for the filing of any substantive claim challenges made pursuant to 42 C.F.R. § 405.1873(a). The parties filed responses on August 20, 2021 and September 29, 2021.

Upon review of the parties' responses, the Board issued a notice on October 27, 2021 of a potential own motion EJR based on arguments raised in the Providers' response to the Medicare Contractor's Substantive Claim Challenge filed on August 20, 2021 and ordered the parties to file comments on the Board's notice by November 27, 2021. The Board further noted that the notice and the parties' comment on that notice would serve to augment the Providers' original pending EJR request filed on June 23, 2021. Comments to the own motion EJR were filed on November 24, 2021 and Noveber 29, 2021. The Board decision with respect to the Providers' request for EJR and the Board's own motion EJR determination are set forth below.

Issues for EJR:

A. The Providers' Request for EJR

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

> The days at issue in th[is] appeal[] are days of care furnished by the Hospitals to patients who were entitled to Medicare Part A and Supplemental Security Income ("SSI") benefits. The issue presented in th[is] appeal[] is whether the intermediary erred in calculating the [SSI] percentage included in the "Medicare fraction"

> for purposes of calculating the Provider's [Disproportionate Share Hospital] DSH payment, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi)."
>
> The Providers respectfully assert that under the rules of statutory construction, CMS [the Centers for Medicare & Medicaid Services] is *compelled to interpret "entitlement to SSI" benefits to include all inpatients who were eligible for and/or enrolled in the SSI program at the time of their hospitalization* ***and***, further, to *furnish the Providers with a listing of those SSI Enrollees/Eligible patients for the relevant hospitalizations so that its DSH adjustments can be recalculated in accordance with the Medicare Act*. Furthermore, [t]he Providers seek a ruling that CMS has failed to provide the them with adequate information to allow them to check and challenge CMS'[] disproportionate patient percentage ("DPP") calculations. The Providers are entitled to this data under Section 951 of the Medicare Prescription Drug, Improvement, and Modernization Act, Pub. L. 108-173. . . . Because the summary data that CMS currently provides only gives providers the underlying data for SSI days that are limited to the three (3) SSI status codes chosen by CMS instead of the full list of the hospital's Medicare patients who are enrolled in SSI and/or eligible for SSI benefits along with their corresponding SSI status codes, and does not give the Providers any meaningful means of challenging the SSI days chosen by CMS to be used in Provider's DPP calculations, CMS continually violates its § 951 mandate . . . .[1]

B. Board's Notice of Proposed Notice of Own Motion EJR

The issues for which the Board is considering for own motion EJR relate to the Providers' challenge to the substantive validity of 42 C.F.R. §§ 413.24(j) and 405.1873 which as found in its substantive cost report brief. In its response to the Medicare Administrative Contractor's ("MAC") substantive claim challenge, the Providers' representative challenged the substantive validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873, and did not appear to present any evidence that it complied with regulations requiring providers submit a specific claim for an item that they are self-disallowing.[2]

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[1] EJR Request at 2-3 (emphasis added).

[2] *See* 42 C.F.R. § 413.24(j)(2) (in order to properly self-disallow a specific item an estimated amount for each specific self-disallowed item must be on the protest line(s) of the providers cost report). 405.1873(a) (in order to receive or potentially receive reimbursement for a specific item, the provider must include in its cost report an appropriate claim for the specific item. . . .the Board must address [whether the cost report included a specific claim for an item]).

Statutory and Regulatory Background:

A. Background on the Medicare Disproportionate Share Hospital ("DSH") Payment

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

> (2) *First computation: Federal fiscal year.* For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

[3] 42 C.F.R. Part 412.
[4] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[5] (Emphasis added.)
[6] (Bold emphasis added and italics emphasis in original.) *See also* 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I).

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

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

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

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

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

[7] 42 U.S.C. § 1382.
[8] 42 U.S.C. §§ 1381a, 1382(a) (emphasis added).
[9] 20 C.F.R. § 416.202.
[10] 42 U.S.C. § 426.
[11] 42 U.S.C. § 426-1.
[12] 20 C.F.R. § 416.204.
[13] 20 C.F.R. §§ 416.1331-1335.
[14] 20 C.F.R. §§ 416.1320-1330.
[15] 20 C.F.R. § 1320.
[16] 20 C.F.R. § 416.207.
[17] 20 C.F.R. § 416.210.
[18] 20 C.F.R. § 416.214.
[19] 20 C.F.R. § 416.215.

5. The individual becomes a resident of a public institutions or prison.[20]

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

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[22] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[23] To compute the Medicare fraction, CMS had to match individual Medicare billing records to individual SSI records.[24] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[25] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[26]

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

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[20] 20 C.F.R. § 416.211.
[21] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[22] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[23] *Id.*
[24] *Id.*
[25] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[26] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[27] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to

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

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

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[33] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data

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individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.

[28] CMS-1498-R at 5.

[29] *Id.*

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

[31] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).

[32] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").

[33] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).

match process."[34] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[35] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[36] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[37]

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[38] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[39] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[40]

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

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[42] The

[34] *Id.* at 50280.
[35] *Id.* at 50280-50281.
[36] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[37] *Id.* at 50285.
[38] CMS-1498-R at 6-7, 31.
[39] *Id.* at 28, 31.
[40] 75 Fed. Reg. at 24006.
[41] CMS-1498-R2 at 2, 6.
[42] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.

Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

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

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

1. Background for Payments and Cost Reporting Requirements

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

Under IPPS, providers are generally paid for each patient discharge after a bill is submitted. The statute, 42 US.C. §§ 1395g(a) and 1395l(e), provide that no payments will be made to a provider unless it has furnished the information, requested by the Secretary needed to determine the amount of payments due the provider under the Medicare program. In general providers submit this information through annual cost reports that cover a 12-month period of time. All providers

[43] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[44] *Id.* at *70555*.
[45] *Id.* at 70551.
[46] *Id.* at 70552.

participating in the Medicare program are required under 42 C.F.R. § 413.20(a) to maintain sufficient financial records and statistical data for proper determination of costs. Moreover, providers must use standardized definitions and follow accounting, statistical, and reporting practices that are widely accepted in the hospital and related fields. Under the provisions of 42 C.F.R. §§ 413.20(b) and 413.24(f), providers are required to submit cost reports annually, with the reporting period based on the provider's accounting year.[47]

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

Until 1988, when the Supreme Court issued its decision in *Bethesda Hospital v. Bowen* ("*Bethesda*"),[48] the Secretary did not allow providers to "self-disallow" a claim for reimbursement. A self-disallowance occurs were the provider submits a cost report that complies with Medicare policy for an item and then appeals an item to the Board that was ***not*** *included in its cost report.* In this situations, the MAC's NPR does not include a disallowance or adjusgment for that item. In *Bethesda*, the U.S. Supreme Court held that despite the providers failure to claim all of the reimbursement they believed should have been made, the plain language of the dissatisfaction requirement in 42 U.S.C. § 1395oo(a)(1)(A) supported Board jurisdiction because the MAC had no authority to award reimbursement in excess of a regulation by which it was bound. Consequently, it would have been futile for the providers to try to persuade the MAC otherwise. The U.S. Supreme Court also stated in *dicta*, that the dissatisfaction requirement might ***not*** be met if providers were to ''bypass a clearly prescribed exhaustion requirement or . . . fail to request from the intermediary reimbursement for all costs to which they are entitled under applicable rules''[49, 50]

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

Subsequently, in 2015, this regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[54] In *Banner*, the provider filed its cost report in accordance with the

[47] *Id.* at 70552-3.
[48] 485 U.S. 399 (1988).
[49] *Id.* at 404-405.
[50] 80 Fed. Reg. at 70554.
[51] *See generally,* 73 Fed. Reg. 30190 (May 23, 2008). (Provider Reimbursement and Appeals Final Rule).
[52] *Id. at* 30195-30200.
[53] 80 Fed. Reg. at 70557.
[54] 201 F. Supp. 3d 131 (D.D.C. 2016).

applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The U.S. District Court for D.C. concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[55]

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

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

Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016. Under this Ruling, "[i]f the PRRB . . . determines that the specific item under appeal was subject to a regulation or other payment policy that bound the Medicare contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, then the pertinent reviewing entity shall not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable), to the specific non-allowable item under appeal; instead, the reviewing entity should apply all other applicable jurisdictional requirements (for example, the amount in controversy and timely filing requirements), and process the appeal in accordance with its usual appeal procedures."[57]

Prior to CMS Ruling 1727-R and concurrent, with the *Banner* litigation, the Secretary promulgated new cost reportinging regulations. Specifically, as part of the November 13, 2015 Final Outpatient Prospective Payment Rule,[58] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim effective for cost reporting period beginning on or after Jauary 1, 2016.[59] The Secretary determined that the requirement that a provider either claim reimbursement for a specific cost, or expressly self-disallow the cost, in its cost report is more appropriately treated as a cost reporting requirement under 42 U.S.C. §§ 1395g and 1395l, as the Secretary cannot make payments to a

[55] *Id.* at 142.
[56] CMS Ruling 1727-R at 5.
[57] *Id*. at 7.
[58] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[59] These regulations were effective for cost reporting periods beginning on or after January 1, 2016 (See 80 Fed. Reg. 70298).

provider without sufficient information on all claims for which the provider believes it should be paid.[60] To that end, the Secretary added a new paragraph (j) to 42 C.F.R. § 413.24. Paragraph (j)(1) of § 413.24 provides that, in order to receive or potentially qualify for payment for a specific item, the provider must include *on its cost report* an appropriate claim for the specific item. *In order to make an appropriate claim for an item* ***on its cost report***, the provider must either claim payment for the item in its cost report where it is seeking payment that it believes is consistent with Medicare policy, or self-disallow the item on the cost report if the provider is seeking payment that it believes may not comport with Medicare policy (for example, where the MAC does not have the authority or discretion to award the payment sought by the provider). In order to properly self-disallow a specific item on the cost report, the provider would have to follow the applicable procedures for filing a cost report under protest.[61]

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

> (1) *General requirement.* In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), must include an appropriate claim for the specific item, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and

[60] *Id*. at 70554.
[61] *Id*. at 70555.
[62] *Id*. at 70298.

> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .

> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[63]

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

Providers' Request for EJR:

The Providers assert that, under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits" narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration ("SSA") for the month in question. The Providers contend that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[64]

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

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the DSH statute. The Providers state that

[63] (Bold and underline emphasis added.)
[64] 75 Fed. Reg. at 50275-86.
[65] *Id.* at 50281.

they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' disproportionate patient percentage ("DPP") calculations which they are entitled to under § 951 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 ("MMA").[66]

Decision of the Board:

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

A. Jurisdiction

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

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[67] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

On July 22, 2021, the Board sent the parties a letter noting that in the case referenced above, one or more of the participants had cost reporting perioding beginning on or after January 1, 2017, and as a result the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are applicable. Both parties have responded to the Board's query as to the applicability of the regulations to the Providers in these cases. Neither party requested that the Board conduct an oral proceeding on the substantive claims challenges.[68]

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[66] Pub. L. 108-173, § 951, 117 Stat. 2066, 2427 (2003).
[67] (Emphasis added.)
[68] In its July 22, 2021 request for information, the Board advised the parties: "If a party desires to have additional evidence or argument considered (e.g., testimony or oral argument), that party must submit a request to the Board with both a description of and an explanation of the need for such additional evidence/argument (whether written or

1. MAC's Substantive Claim Challenge

The MAC filed a Substantive Claim Challenge for only one participant. Specifically, the MAC does not believe that Great River Medical Center (Prov. No. 16-0057, FYE 6/30/17) ("Great River"), a participant in this group appeal, claimed reimbursement for the DSH SSI Ratio Dual Eligible days issue in its cost report and none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply.

With respect to Great River, the MAC contends that the Provider did not claim reimbursement for DSH Dual Eligible Days on its cost report, nor did it include the issue as a protested amount. The MAC notes that the Provider appealed adjustment 6 which reduced the percentage of SSI recipient patient days to Medicare Part A patient days by 1.23 and reduced the DSH percentage by 1.01. The MAC asserts this is not an indication that the Provider sought to claim the full amount of reimbursement for dual eligible days. Further, there was no amount ($0) claimed as Part A Protested amounts. Consequently, the MAC concludes that the Board should find that Great River Medical Center (provider no. 16-0057, FYE 6/30/2017) did not file a claim for the dual eligible days issue.

2. Providers' Response to the MAC's Substative Claim Challenge

In this case, the Representative does not refute the MAC's assertion that Great River did not protest the dual eligible days issue. Rather, the Provider raise arguments, *discussed infra*, about why the regulations, 42 C.F.R. §§ 413.24(j) and 405.1873, are invalid/nonsensical.

The Provider asserts that the MAC filed a substantive claim challenge indicating that the Provider is subject to the "substantial claim" requirements of 42 C.F.R. §§ 413.24(j) and 405.1873, effective with cost reporting periods beginning on or after January 1, 2016. However, the Provider notes that, prior to the January 1, 2016 period, a nearly identical regulatory policies were stricken by the Federal courts in *Bethesda Hospital Association v. Bowen*[69] (*"Bethesda"*) and *Banner Heart Hospital v. Burwell ("Banner").*[70] The Provider believes that, pursuant to 42 U.S.C. § 1395oo(a), it only needs to be dissatisfied with the final determination of the MAC and meet the monetary threshold for Board jurisdiction.

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

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oral). Otherwise, following the above referenced filing deadline, the Board will proceed with issuing a ruling on § 413.24(j) compliance issue(s) based solely on the record before it."

[69] 485 U.S. 399, 400 (1988).

[70] 201 F.Supp. 3d 131, 133 (D.D.C. 2016).

The Provider notes that when enacting the 2008 update to the Board's regulations at 42 C.F.R. § 405.1835(a)(1), the Secretary instituted the requirement that in order to preserve their appeal rights, providers must either claim a cost on their cost reports or file the matter under protest. In *Banner*, the D.C. District Court in *Banner* examined a challenge to the validity of this regulatory requirement. The Provider asserts that the D.C. District Court determined that satisfaction with a regulatory scheme cannot be imputed from a provider's silence when everyone knows that it would be futile to present such claim to the MAC and that the D.C. District Court found that submitting a regulatory challenges to the MAC was unnecessary and conflicted with the plain meaning of 42 U.S.C. § 1395oo. The Provider then asserts that the Administrator[71] subsequently implemented CMS Ruling CMS-1727-R to eliminate the regulatory self-disallowance requirements prior to January 1, 2016.

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

3. Board Notice of Potential Own-Motion EJR

On September 1, 2021, the Board sent the parties a letter that contained: (1) a ruling on jurisdiction and the Medicare Contractor's substantive claim challenge; and (2) notice of a potential own motion EJR relative to 42 C.F.R. §§ 413.24(j) and 405.1873.

The Board issued the October 27, 2021 notice of potential Own Motion EJR to notify the parties that the Board is considering an own-motion EJR of certain questions that the Provider raised in its September 29, 2021 filing challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. The Board further informed the parties that the own motion EJR would, if issued, serve to augment the Provider's original pending EJR request filed on June 23, 2021 that is currently stayed per the Board's letters dated July 22, 2021 and October 27, 2021.[72]

Accordingly, the Board required the parties to file comments within 30 days (*i.e.*, by Friday, November 26, 2021) regarding whether a Board own motion EJR (pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842) is appropriate for the above questions raised by the Provider. The Provider timely filed comments on the Board's notice of potential EJR on Wednesday, November 24, 2021. In contrast, the MAC filed comments one day late on Monday, November 29, 2021.

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[71] of the Centers for Medicare & Medicaid Services.

[72] In this regard, the Board noted that, if the Board were to grant EJR: (1) pursuant to 42 C.F.R. § 405.1873(f) the Board's ruling on a substantive claim challenge impacts whether the provider will ultimately receive reimbursement; and (2) if the Board ultimately grants EJR in this case, 42 C.F.R. § 405.1873(d)(2) specifies that the Board must include its findings on any substantive claim challenge raised by a party, notwithstanding the questions raised by the Provider challenging the legal validity of that regulation.

The Providers have no objection to the Board's notice of potential own-motion EJR. In contrast, the MAC asserts that, to the extent the Providers now wish to challenge 42 C.F.R. § 413.24(j), they should have and were required to do so as part of its appeal request. Accordingly, the MAC contends that the Board lacks jurisdiction over the Provider's challenge to §§ 413.24(j) and 405.1873 as the Provider's challenge to these regualtions was first raised in the Provider's response to the MAC's Substantive Caim Challenge. To the extent the Board finds that it does have jursdiciton over the challenge to 42 C.F.R. § 413.24(j), the MAC does not oppose the Board's notice of potential own-motion EJR.

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

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[73] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.[74]

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[75] 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.[76] In this case, although all 5 participants in the optional group are subject to § 413.24(j), the MAC only filed a Substantive Claim Challenge against one of the participants, Great River Medical Center (Prov. No. 16-0057, FYE 6/30/2017).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made regarding the other 4 participants,[77] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to

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[73] (Emphasis added.)

[74] There are a number of other hospitals in this appeal with fiscal years beginning on or after January 1, 2016. 42 C.F.R. § 405.1873 does not require that the Board initiate a review of costs that may not have been protested. The regulation states that:

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

[75] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

[76] *See* 42 C.F.R. § 405.1873(a).

[77] 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."

determine whether an appropriate cost report claim was made for the other 4 participants. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for these other 4 participants (*i.e.*, all the other participants outside of Great River Medical Center). Accordingly, the Board's findings relative to compliance with the cost reporting rquirements in § 413.24(j) is limited to Great River Medical Center.

a. Board Findings on Meeting Appropriate Cost Repor Claim Requirements

In this case, Great River Medical Center (Prov. No. 16-0057, FYE 6/30/17) did not establish that it had filed the issue that is the subject of this appeal under protest on its as-filed cost report. Indeed, the Provider in its response to the MAC's Substantive Claim Challenge conceded that it did not claim or protest on its as-filed cost report the *additional* DSH reimbursement being sought due to the alleged *error* in the calculation of the SSI percentage and rather alleges that, based on *Bethesda*, simply including a claim on the cost report for a DSH adjustment is enough. The arguments presented are simply reiterations of the Provider's challenge to the validity of 42 C.F.R. § 413.24(j) and § 405.1873 as discussed *infra*.

Contrary to the Provider's assertion, the Board is bound by and must apply § 413.24(j) and § 405.1873 as relevant. Here, it is clear from the record that Great River did not comply with its obligation under § 413.424(j)(1) to "include an appropriate claim for the ***specific*** item"[78] by either: (1) "[c]laiming ***full*** reimbursement . . . for the specific item"[79] (*i.e.*, claiming the ***full*** reimbursement it believes it is due as a result of the alleged error in the SSI fraction as used in the DSH adjustment calculation); or (2) protesting the issue in this appeal following the procedures set forth in § 413.424(j)(2) "for properly disallowing the specific item in the provider's cost report as a protested amount." Here, the Provider failed to make a claim for the "specific item" (*i.e.*, claim reimbursement for the *additional* class of days that it alleges were improperly excluded from the SSI fraction) or protest the "specific item" (*i.e.*, protest the exclusion of the class of days at issue in this appeal from the SSI fraction). The Provider failed to include any protested items on its cost report as reflected by no reimbursement amount ($0) being entered on the protest

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

[79] (Emphasis added.)

line of the cost report and none of the exceptions in 42 C.F.R. § 413.24(j)(3)(i)-(iii) apply (in particular, there is no adjustment for the issue under appeal).

Based on the above, the Board finds that Great River Medical Center (Prov. No. 16-0057, FYE 6/30/17) did not specifically include an appropriate cost report claim for the group's DSH SSI Fraction Dual Eligible Days issue as required under 42 C.F.R. § 413.424(j) and none of the execeptions specified therein apply.

b. Board Ruling on its Notice of Potential Own-Motion EJR

Contrary to the MAC's assertion, the Board finds that it has jurisdiction over the Provider's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 because the Board had jurisdiction over the issue being appealed (*i.e.*, the group's SSI entitlement/eligibility issue) and the Provider's challenge to those regulations is an outgrowth of that appeal and only became relevant as a defense to the MAC's Substantive Claim Challenged filed pursuant to 42 C.F.R. § 405.1873(a). The Provider's challenge to §§ 413.24(j) and 405.1873 is substantive as demonstrated by the following allegations made by the Provider:

- "42 C.F.R. §§ 413.24(j) and 405.1873 violate the Providers' statutory right to a meaningful appeal under 42 U.S.C. § 1395oo(a), as already determined by *Bethesda*, *Banner*, and *Bayshore*."

- "The 2016 Regulation additionally violates each Provider's statutory right to an appeal under 42 U.S.C. § 1395oo(a) because a procedural finding that payment for the Providers' claims is foreclosed voids the Board's jurisdiction over the claims."

EJR of these issues is appropriate as there are no factual issues for Board resolution and the Board does not have the authority to declare these regulations invalid.

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

As discussed above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a *revised* data match.[80] The Secretary also stated in the Ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the *revised* data match process to be published through rulemaking.[81]

[80] CMS Ruling 1498-R at 27.
[81] *Id.* at 31.

Contemporaneous with CMS Ruling 1498-R[82] the Secretary published a proposed IPPS rule[83] which proposed to adopt a revised data process for cost reports covered by Ruling 1498-R ***and*** for cost reports beginning on or after October 1, 2010. The Secretary adopted this proposed rule as part of the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[84]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[85]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[86]

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

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[82] *Id.* at 5.
[83] 75 Fed. Reg. 23852, 24002-07.
[84] 75 Fed. Reg. at 50277.
[85] (Medicare) Enrollment Database.
[86] 75 Fed. Reg. at 50285.

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[87] Moreover, it is clear that the Uncodified SSI Data Match Regulation specifies which PSC codes determine SSI entitlement for purposes of calculating SSI fractions under 42 C.F.R. § 412.106(b)(2).

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

D. Summary of the Board's Findings:

The Board makes the following findings:

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

2) The participant, Great River Medical Center (Prov. No. 16-0057, FYE 6/30/17) does not qualify or potentially for reimbursement for the optional group's issue because it failed to include an appropriate cost report claim for that issue as required by 42 C.F.R. § 413.424(j) and none of the execptions specified therein are applicable.

3) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule and the challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873, there are no findings of fact for resolution by the Board;

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

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

   A. Whether the Uncodified SSI Data Match Regulation as adopted in the preamble to the FY 2011 Final IPPS Rule is valid; and

   B. Whether 42 C.F.R. §§ 413.24(j) and 405.1873 are substantively valid.

[87] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

Accordingly, the Board finds that the questions of the validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) as well as the substantive vailidaty of 42 C.F.R. §§ 413.24(j) and 405.1873 aproperly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes the case.

Board Members Participating:

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

For the Board:

12/17/2021

X Clayton J. Nix

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

cc: Judith Cummings, CGS
Wilson Leong

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RE: ***EJR Determination Hall Render DSH Dual Eligible SSI Patient Days Groups***

17-1408G	Hall Render 2010 DSH Medicare Fraction Dual Eligible Days Group III
17-1600G	Hall Render 2015 Medicare Fraction Dual Eligible Days Group
17-1771G	Hall Render 2012 DSH SSI Fraction Dual Eligible Days Group IV
18-0133G	Hall Render 2014 DSH SSI Fraction Dual Eligible Days Group II
18-0329G	Hall Render 2011 DSH SSI Fraction Dual Eligible Days Group IV
18-0334G	Hall Render 2009 DSH SSI Fraction Dual Eligible Days Group III
18-1466G	Hall Render 2015 DSH SSI Fraction Dual Eligible Days Group II
18-1471GC	Truman 2011 SSI Fraction Dual Eligible Days CIRP

Dear Ms. Griffin:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 20, 2020 request for expedited judicial review ("EJR") in the above-referenced appeal. The Board's decision with respect EJR is set forth below.

I. Effect of COVID -19 on Board Operations

By letter dated April 15, 20200, the Board sent the Group Representative notice for these groups that the 30-day time period for issuing an EJR had been stayed consistent with Board Alert 19. As explained below, that stay remains in effect. On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Board Alert 19, notifying affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." On April 15, 2020, subsequent to the submission of the EJR request, the Board notified you of the Issue in relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, i.e., whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.

Although the ***hard copy*** Schedules of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom prior to the issuance of Alert 19, the Board did not receive the EJR request for the above-referenced appeals in its office until March 20, 2020, after the Board and its staff had begun to telework. Consequently, the Board did not have access to its office to locate the Schedules of Providers. Further, the Board has not resumed normal operations, but is attempting to process EJR requests expeditiously and is still governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

II. Issue in Dispute

The issue for which the Board is considering EJR is:

> [W]hether the Providers' Medicare DSH [disproportionate share hospital] reimbursement calculations were understated due to the Centers for Medicare [&] Medicaid Services ("CMS" or "Agency") and the Medicare Administrative Contractors' ("MACs'") failure to include all patient days for patients who were enrolled in and eligible for in the SSI [Supplement Security Income] program but did not receive an SSI cash payment for the month in which they received services from the Providers ("SSI Eligible Days"), in the numerator of the Medicare Fraction of the DSH percentage, as required by 42 U.S.C. § 1395ww(d)(5)(F)(vi).[1]

III. Medicare Disproportionate Share Hospital (DSH) Payment Background

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

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[1] Providers' EJR Request at 2.
[2] 42 C.F.R. Part 412.
[3] 42 U.S.C. § 1395ww(d)(5)(F)(i)(I).
[4] (Emphasis added.)

> (2) *First computation: Federal fiscal year*. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS –
>
> (i) Determines the number of patient days that –
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were **entitled to** both Medicare Part A (including Medicare Advantage (Part C)) and **SSI**, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that –
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[5]

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

The SSI program is a federal cash assistance program for low-income individuals who are aged, blind, or disabled,[6] administered by the Social Security Administration ("SSA"). The statutory provisions governing SSI, generally, do not use the term "entitled" to SSI benefits. Rather, the SSI statutory provisions typically refer to whether an individual is "eligible for benefits."[7] In order to be "eligible" for SSI benefits, a person must be: (1) 65 years of age or older, blind or disabled; (2) a lawful resident of the United States; (3) have limited income and resources; (4) not be fleeing to avoid prosecution for a crime or violating a condition of parole; and (5) file an application for benefits.[8]

In contrast, the Medicare program is an insurance program where an individual is automatically "entitled" to Medicare Part A when the person reaches age 65 and is entitled to Social Security benefits or becomes disabled and had been entitled to disability benefits for 24 calendar months.[9]

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

In addition, the Medicare program provides that certain qualifying individuals with end stage renal disease are entitled to Medicare Part A.[10]

Unlike entitlement for Medicare Part A benefits, an individual who is currently eligible for SSI benefits may later become *in*eligible for SSI benefits. In this regard, SSA conducts periodic redeterminations to ensure continued eligibility[11] and may terminate,[12] suspend[13] or stop payments to individuals who are either temporarily or permanently ineligible for payment of SSI benefits.[14] In particular, SSI eligibility may be lost if a person no longer meets the basic requirements. For example, an individual may lose SSI eligibility if the individual is no longer disabled or the individual meets one of the following reasons set forth in §§ 416.207-416.216:

1. The individual fails to give the SSA permission to contact financial institutions;[15]
2. The individual fails to apply for other benefits to which the individual may be entitled;[16]
3. The individual fails to participate in drug or alcohol addiction treatment;[17]
4. The individuals is absent from the United States for more than 30 days;[18] or
5. The individual becomes a resident of a public institutions or prison.[19]

In addition, under certain circumstances, SSA may not pay benefits for administrative reasons, such as removal of a representative payee, an unknown address for the beneficiary, or because of income from a previous month.[20]

After the Medicare DSH statutory provisions were enacted in 1984, CMS (then known as the Health Care Financing Administration ("HCFA")) announced that the Secretary of Health and Human Services, rather than hospitals, would be solely responsible for computation of the Medicare fraction because the data necessary to calculate the Medicare fraction is voluminous and much of this data needed to be obtained from another agency, SSA.[21] CMS noted that, as of 1986, the data sources for the computation of the Medicare fraction included approximately 11 million billing records from the Medicare inpatient discharge file and over 5 million records from the SSI file compiled by SSA.[22] To compute the Medicare fraction, CMS had to match

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[10] 42 U.S.C. § 426-1.
[11] 20 C.F.R. § 416.204.
[12] 20 C.F.R. §§ 416.1331-1335.
[13] 20 C.F.R. §§ 416.1320-1330.
[14] 20 C.F.R. § 1320.
[15] 20 C.F.R. § 416.207.
[16] 20 C.F.R. § 416.210.
[17] 20 C.F.R. § 416.214.
[18] 20 C.F.R. § 416.215.
[19] 20 C.F.R. § 416.211.
[20] *See* SSA Program Operations Manual ("POMS") § SI 02301.201 (describing certain SSI post-eligibility events on the internet at https://secure.ssa.gov/apps10/poms.nsf/lnx/0502301201).
[21] 51 Fed. Reg. 31454, 31459 (Sept. 3, 1986).
[22] *Id.*

individual Medicare billing records to individual SSI records.[23] Considering the administrative burdens and complexity of the data matching process, CMS concluded that the Secretary would be responsible for the data matching process, which she would conduct retrospectively for every eligible Medicare hospital on a "federal fiscal year" basis—that is, based on discharges occurring in the federal fiscal year.[24] CMS notifies Medicare contractors of the SSI ratios after they are calculated. CMS currently makes this notification by posting the resulting SSI percentages on its website. Medicare contractors then use the posted SSI ratios to calculate the Medicare DSH percentage to determine each qualifying hospital's Medicare DSH payment adjustment.[25]

The Medicare DSH payment adjustment has been the subject of much litigation and, from that litigation, the following case is of particular relevance to this appeal: *Baystate v. Leavitt*, 545 F. Supp. 2d 20 *as amended* 587 F. Supp. 2d 37, 44 (D.D.C. 2008) ("*Baystate*"). In *Baystate*, the plaintiff alleged that the Secretary's process to identify and gather the data necessary to calculate each hospital's SSI ratio was deficient and the Court remanded the case to the Administrator for further action. The Board notes that this case discusses the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[26]

On April 28, 2010, the Secretary through CMS acted on the *Baystate* remand order and published CMS Ruling CMS-1498-R ("Ruling 1498-R"). Specifically, the Ruling stated that CMS had implemented the *Baystate* remand order by recalculating the plaintiff's SSI fractions and Medicare DSH payment adjustments using a revised data matching process that used "updated and refined SSI eligibility data and Medicare records, and by matching individuals' records with reference to Social Security numbers (SSNs) as well as HICANs and Title II numbers."[27] The Ruling also stated that "in the FY 2011 proposed rule, CMS is proposing to adopt the same revised data matching process" for use with all hospitals and that "[i]n the forthcoming FY 2011 IPPS final rule, CMS expects to respond to public comments filed on the

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[23] *Id.*
[24] *Id.* at 31459–31460; 42 C.F.R. § 412.106(b).
[25] 42 C.F.R. § 412.106(b)(5); 42 C.F.R. § 405.1803.
[26] *Baystate* began with a hearing before the Board. *See Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006), *modified by*, CMS Adm'r Dec. (May 11, 2006). The Board heard extensive testimony on the Secretary's then-existing data match process. This included testimony from several SSA employees on the data tapes historically sent from SSA to CMS that included "42 monthly indicators (ones and zeros) denoting the payment or non-payment of Federal SSI cash benefits during the period covered by the SSA tape." *Id.* at 11 (citations omitted). Further, this testimony established that SSA's program would "assign a '1' to a month if the CMPH field shows one of two payment codes, C01 (current pay status) or M01 (manual or forced pay), and the FAM field reflects an amount due for the month" and that "[o]therwise, the program assigns a '0' to that month." *Id.* The provider in *Baystate* contested among other things: (1) "the omission of SSI records relating to individuals who received a forced payment from an SSA filed office; (2) "the omission of SSI days associated with individuals whose SSI benefits were temporarily on hold or in suspense when SSA ran each year's SSI tape;" (3) "the omission of SSI days associated with individuals whose benefits were restored or retroactively after SSA ran each year's tape;" and (4) "the omission of individuals who were entitled to non-cash Federal SSI benefits." *Id.* at 23. The Board's discussion of these contentions confirms SSI days were counted when there was actual SSI cash benefits. *See id.* at 26-30. The CMS Administrator's decision and the ensuing decision of the D.C. District Court also contain references to the Secretary's policy. *See, e.g.,* Adm'r Dec. at 5, 16, 39, 41, 48-49; 545 F. Supp. 2d at 28-29 n.13 & n.17, 36-39.
[27] CMS-1498-R at 5.

proposed new data matching process, make any changes to such matching process that seem appropriate, and adopt finally a new data matching process."[28] Finally, CMS stated that it would "use that new data matching process in calculating SSI fractions and DSH payments for specific claims that are found to qualify for relief under this Ruling."[29]

Consistent with Ruling 1498-R, the Secretary published the new data matching process in the FY 2011 IPPS proposed rule published on May 4, 2010.[30] The proposed rule includes references to the Secretary's historical practice of basing "entitled to . . . SSI" under 42 C.F.R. § 412.106(b)(2) on actual payment of SSI cash benefits.[31]

The Secretary finalized that data matching process in the FY 2011 IPPS final rule published on August 16, 2010 ("FY 2011 IPPS Final Rule").[32] Significantly, in the preamble to the FY 2011 IPPS Final Rule, CMS acknowledged a public comment that: (1) requested that "CMS include both paid and unpaid days for both SSI entitlement and Medicare entitlement such that there would be consistency between the numerator and denominator of the SSI fraction"; and (2) provided examples of "several SSI codes that represent individuals who were eligible for SSI but not eligible for SSI payments, that should be included as SSI-entitled for purposes of the data match process."[33] CMS responded in detail to this comment and explained that CMS interprets SSI entitlement to correspond with any month for which an individual *receives* payment of SSI benefits. In this regard, CMS stated that the three SSI codes denoted as C01, M01, and M02 "accurately captures all SSI-entitled individuals during the month(s) they are entitled to receive SSI benefits."[34] CMS explicitly rejected the inclusion of other SSA codes because "SSI entitlement can change from time to time" and none of these codes "would be used to describe an individual who was entitled to receive SSI benefits during the month that one of these codes was used."[35] Finally, in the preamble, CMS confirms that "[t]he same data matching process [used for FY 2011 and beyond] will be used to calculate SSI fractions for cost reporting periods covered under the Ruling [1498-R]."[36]

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[28] *Id.*
[29] *Id.* at 5-6.
[30] 85 Fed. Reg. 23852, 24002-24007 (May 4, 2010).
[31] *See, e.g.,* 75 Fed. Reg. at 24003 (discussing SSI cash payment issues discussed in the *Baystate* decision), 24003-24004 (discussing the proposed matching process where "[t]he SSI eligibility file serves as the system of record for whether or not SSA made a payment of SSI benefits to an individual who applied for SSI"), 24004-06 (discussing the time of the matching process including how "it is important to find an appropriate balance between administrative finality (that is, the final settlement of a hospital's cost report) and the inclusion of retroactive SSI eligibility determinations and the lifting of SSI payment suspensions by using the best and latest available SSI eligibility data at the time of cost report settlement benefits").
[32] 75 Fed. Reg. 50041, 50280-50281. (Aug. 16, 2010).
[33] *Id.* at 50280.
[34] *Id.* at 50280-50281.
[35] *Id.* This include all codes with the "S" prefix indicating a suspension of payment; codes beginning with "N" for nonpayment; code "E01" indicating that the individual had countable income which eliminated the SSI payment; and code "E02" indicating that the patient was not entitled to SSI benefits during that month but became entitled during a subsequent month.
[36] *Id.* at 50285.

While the new data matching process established in the preamble to the FY 2011 IPPS Final Rule was effective October 1, 2010 (*i.e.*, for FY 2011 and forward), Ruling 1498-R directed that the Medicare contractors apply "the same, unitary relief" consisting of SSI fractions that the Secretary had calculated using the new "suitably revised" data matching process to: (1) any Medicare cost report that had not been settled; and (2) all properly pending Medicare DSH appeals of the SSI fraction data matching process issue.[37] The Ruling noted that hospitals dissatisfied with the initial or revised NPR issued using the new SSI ratios in the Medicare DSH adjustment calculation could seek administrative and judicial review provided they met the jurisdictional and procedural requirements of 42 U.S.C. § 1395oo, the Medicare regulations, and other agency rules and guidelines.[38] In the FY 2011 IPPS Final Rule, the Secretary explicitly recognized that "[t]he data matching process provisions of the Ruling would apply to . . . open cost reports for cost reporting periods beginning prior to October 1, 2010 (that is those preceding the effective date of the FY 2011 IPPS final rule)."[39]

Finally, on April 22, 2015, CMS published Ruling 1498-R2 modifying and amending Ruling 1498-R by allowing hospitals to elect whether to use new Medicare SSI fractions calculated on the basis of "total days" or "covered days" for cost reports involving patient discharges *prior* to October 1, 2004.[40]

As a result of the Rulings, new regulation, and new data match process, CMS calculated SSI percentages for the Providers for all of fiscal years at issue in this CIRP group appeal.[41] The Providers have appealed original NPRs a based on the methodology articulated in the preamble, *i.e.*, use only the three SSI codes to denote SSI eligibility.

IV. Providers' Request for EJR

The Providers assert that under the rules of statutory construction, the Secretary is compelled to interpret "entitled to SSI" benefits to include all inpatients who were enrolled in the SSI program at the time of their hospitalization. The Providers point out that, overtime, the Secretary has expanded the definition of entitled to benefits, but the expanded definition did not address the rift between Medicare Part A beneficiaries and SSI beneficiaries who are described in the DSH statute as "entitled to benefits." The Providers explain that the Secretary continues to construe "entitled to [SSI] benefits"[42] narrowly. In order to be counted in the Medicare fraction numerator of the DSH calculation, an SSI enrollee must actually have received a cash payment from the Social Security Administration (SSA) for the month in question. The Providers contend

[37] CMS-1498-R at 6-7, 31.
[38] *Id.* at 28, 31.
[39] 75 Fed. Reg. at 24006.
[40] CMS-1498-R2 at 2, 6.
[41] CMS published the SSI ratios for FY 2012 on or about June 12, 2014. SSI ratios are published and can be accessed at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.
[42] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

that this action excludes SSI enrollees otherwise qualified for and receiving non-cash benefits under the SSI program.[43]

The Providers note that in administering the SSI program, SSA assigns each beneficiary a Patient Status Code (PSC). The codes are made up of two elements: a single letter code reflecting payment status and a numeric code indicating the reason for the payment status. Of the 77 PSC codes used by SSA, the Secretary announced in the Federal Register that only three PSC codes, C01, M01 and M02, are counted as "entitlement" for purposes of the DSH statute.[44] Thus, the Providers allege the other 74 codes used by SSA to determine payment status result in a significant number of SSI enrollees being excluded from the numerator of the Medicare fraction for reasons that have no bearing on their eligibility for or entitlement to SSI benefits. The Providers believe that the SSI enrollees remain entitled to SSI regardless of whether cash payment is received in the month of hospitalization.

Further, the Providers assert in their request for EJR that CMS should provide the Providers with a listing of those SSI enrollees for the relevant hospitalizations so that they can ensure that their DSH adjustments were calculated in accordance with the Medicare statute. The Providers state that they are seeking a ruling that CMS has failed to furnish the Providers with adequate information to allow them to check and meaningfully challenge CMS' DPP calculations which they are entitled to under Section 951 of the Medicare Prescription Drug, Improvement and Modernization Act, P.L. 108-173.

V. Decision of the Board

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

A. Jurisdictional Determination

The participants that comprise the group appeals within this EJR request have filed appeals involving calendar years 2009, 2010, 2011, 2012, 2014, and 2015.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the Dual Eligible Days issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital*

[43] 75 Fed. Reg. at 50,275-286.
[44] *Id.* at 50,281.

Association v. Bowen ("*Bethesda*").[45] 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.[46]

On August 21, 2008, new regulations governing the Board were effective.[47] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[48] 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.[49]

The Secretary did not appeal the decision in *Banner* and decided to largely apply the holding to certain similar administrative appeals. Effective April 23, 2018, the CMS Administrator implemented CMS Ruling CMS-1727-R which involves dissatisfaction with the Medicare Contractor determinations for cost report periods ending on December 31, 2008 and which began before January 1, 2016, Under this ruling, where the Board determines that the specific item under appeal was subject to a regulation or payment policy that bound the Medicare Contractor and left it with no authority or discretion to make payment in the manner sought by the provider on appeal, the protest requirements of 42 C.F.R. § 405.1835(a)(1)(ii) were no longer applicable. However, a provider could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest. The Board finds that the "entitled to benefits" question is governed by 42 C.F.R. § 412.106(b)(2)(i)(B), which is a regulation that left the Medicare Contractors without the authority to make the payment in the manner sought by the Providers in these cases. Consequently, the Board finds that it has jurisdiction over the Providers in these cases.

The Board has determined that the participants involved with the instant EJR request are governed by CMS Ruling CMS-1727-R. In addition, the participants' documentation shows that the estimated amount in controversy exceeds $50,000 in each appeal, as required for a group

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[45] 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.).
[46] *Bethesda at 1258-59.*
[47] 73 Fed. Reg. 30,190, 30,240 (May 23, 2008).
[48] 201 F. Supp. 3d 131 (D.D.C. 2016)
[49] *Banner* at 142.

appeal.[50] The appeals were timely filed. Based on the above, ***except as noted below***, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

1. Case 17-1771G: Improper Transfer; Issue Not Appealed by Participant No. 4 (Memorial Healthcare, Prov. No. 23-0121. FYE 12/31/2012)

The Board notes that it recently ***denied*** the request of Memorial Healthcare (Prov. No. 23-0121) to transfer an SSI/DSH issue for its fiscal year ending ("FYE") December 31, 2012 from Case No. 16-0023 to Case No. 17-1771G. On March 19, 2021, the Board found that the relevant issue statement in Case No. 16-0023 was broad, vague, and did not specifically address the Dual Eligible Days issue. As a result, the Board denied the request to transfer its individual appeal issue to Case No. 17-1771G and dismissed the relevant issue from the individual appeal ***in its entirety***.[51] The Board further notes that by letter dated October 4, 2021, the Board reaffirmed this dismissal *in Case No. 16-0023* and the denial of transfer from Case No. 16-0023 to Case No. 17-1771G. Accordingly, *based on the ruling in Case No. 16-0023*, the Board hereby finds that Memorial Healthcare (Prov. No. 23-0121) is ***not*** a participant included in Case No. 17-1771G and is not properly part of the EJR request.[52]

2. Cases Nos. 18-1466G and 17-1600G: 13 Participants with Duplicate Issue in Case No. 18-1465G

In Case No. 18-1466G, the Medicare Contractor filed a jurisdictional challenge on August 26, 2021 contending that thirteen (13) Providers are also participants in the optional group appeal under Case No. 18-1465G (Hall Render CY 2015 DSH SSI Post 1498R Data Match Group II), and that both cases contain the same issue. Likewise, there is a similar challenge alleging that two providers in Case No. 17-1600G (Hall Render 2015 Medicare Fraction Dual Eligible Days Group) are also in that same optional group appeal under Case No. 18-1465G.

The Board finds that the other optional group case cited above (*i.e.*, Case No. 18-1465G) is ***not*** duplicative, but rather deal with a different issue.[53] The SSI data match issue as presented in

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[50] *See* 42 C.F.R. § 405.1837.

[51] *See* Jurisdictional and EJR Determination for Case Nos. 15-1976, 16-0023 (Mar. 19, 2021); Notices of Reopening and Reconsideration of Jurisdictional and EJR Determination for Case Nos. 15-1976, 16-0023 (Oct. 4, 2021).

[52] The Board notes that a Jurisdictional Challenge was filed in Case No. 17-1771G by the Medicare Contractor outlining this same issue, to which the Provider responded on August 4, 2021. Since the issue has already been dismissed from the underlying individual appeal (Case No. 16-0023) and the transfer to Case No. 17-1771G was denied, the Board finds that the Jurisdictional Challenge in Case No. 17-1771GC as it relates to Memorial Healthcare, Prov. No. 23-0121, FYE 12/31/2012 is moot.

[53] The Board notes that 42 C.F.R. § 405.1837(b) specifies that there may be only one common issue per group appeal. To the extent, the Providers in Case No. 18-1465G maintain that the group appeal contains another issue *in addition to the SSI data match issue* (*e.g.*, the SSI entitlement/eligible days issue in the instant appeals), then the Board will address the prohibited additional issue as part of Case No. 18-1465G and take remedial action such as dismissal of any such prohibited additional issue, as appropriate.

Case No. 18-1465G is a technical issue which alleges that, notwithstanding the revisions CMS made to its data match process following *Baystate*, there are *still* systematic errors that exist with CMS' revised data matching process and, therefore, it does not properly capture all SSI eligible individuals that should be captured when the revised data matching process as defined by CMS is applied and carried out. In contrast, in Case Nos. 18-1466G and 17-1600G, the Providers dispute CMS's interpretation of the statutory phrase "entitled to [SSI] benefits"[54] and maintains that it should be more broadly interpreted so that additional SSI days are captured in the numerator of the Medicare fraction (*e.g.*, the Providers maintain days where the patient may only be receiving an SSI medical benefit but no cash SSI benefits should be included in the DSH Medicare numerator). Accordingly, the Board finds that these are not duplicative cases.

3. Case No. 17-1408G – Issue Not Appealed by Participant No. 7 (Univ. of Wisconsin Hospitals, Prov. No. 52-0098, FYE 6/30/2010)

With respect to Participant No. 7 in Case No. 17-1408G (University of Wisconsin Hospitals, Prov. No. 52-0098, FYE 6/30/2010), the Board hereby ***dismisses*** the Provider from the case because the SSI issue that was appealed was ***not*** the issue for which EJR has been requested. The complete description of the issue in this Provider's individual appeal was:

> Medicare regulations at 42 CFR §412.106(b)(2)(i)(B) address the computation of the SSI percentage used in the determination of a hospital's disproportionate patient percentage. As indicated in the section, the calculation should be based on services "…*furnished to patients who during that month were entitled to both Medicare Part A (including Medicare Advantage (Part C)) and SSI…*" During the FY10 field audit, the Intermediary improperly determined the Medicare DSH reimbursement by not permitting the Provider to obtain and reconcile the SSI data maintained by CMS with Provider records, as noted in adjustment #32 (attached). ***Historically***, there have been ***inaccuracies*** in the SSI calculation and CMS has even gone so far as to review and publish revised ***data***.[55] In the past providers have been allowed to review the detailed data to determine this critical component of the DSH calculation was calculated correctly. As the SSI ratios were re-released by CMS there was a period of time where providers were unable to submit requests to review this detailed data. In light of this, *the provider has **not** received the data necessary to confirm and validate the SSI percentage* that is used in the final Cost Report. The provider is appealing this adjustment.
>
> The estimated reimbursement impact is $973,648.[56]

[54] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).
[55] (Emphasis added.)
[56] (Emphasis added.)

The Board finds that this issue statement does not comply with 42 C.F.R § 405.1835(b) or Board Rule 8.1. Under 42 C.F.R. § 405.1835(b)(2) (2013), a provider's written request for hearing must contain, "*for each **specific** item at issue,"* a separate explanation of why, and a description of how, the provider is dissatisfied with the *specific* aspects of the final determination under appeal:

> (b) *Contents of request for a Board hearing*. The provider's request for a Board hearing must be submitted in writing to the Board, and the request **must include the elements described in paragraphs (b)(1) through (b)(4) of this section**. If the provider submits a hearing request that does not meet the requirements of paragraph (b)(1), (b)(2), or (b)(3) of this section, the Board may dismiss with prejudice the appeal, or take any other remedial action it considers appropriate. . . .
>
> (2) An explanation (**for each specific item at issue**, see paragraph (a)(1) of this section) of the provider's dissatisfaction with the intermediary's or Secretary's determination under appeal, **including an account of all of the following**:
>
> (i) Why the provider believes Medicare payment is incorrect **for each disputed item** (or, where applicable, **why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment**).
>
> (ii) How and why the provider believes Medicare payment must be determined differently **for each disputed item**.[57]
>
> (iii) If the provider self-disallows a specific item, a description of the nature and amount of **each self-disallowed item** and the reimbursement or payment sought **for the item.**[58]

Accordingly, the regulations prescribe that if a provider submits a hearing request that *does not* meet the requirements of (b)(1), (2), or (3), the Board *may dismiss* the appeal with prejudice or take any other remedial action it considers appropriate.[59]

In keeping with the above-quoted regulation's specificity requirement, the Board's Rules in effect at the time that the Provider filed its individual appeal stated the following:

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[57] (Bold emphasis added.)
[58] (Bold emphasis added.)
[59] 42 C.F.R. § 405.1835(b).

> **Rule 8—Framing Issues for Adjustment Involving Multiple Components**
>
> **8.1 – General**
> Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described *as narrowly* as possible using the applicable format outlined in Rule 7. See common examples below.
>
> **8.2 – Disproportionate Share Cases** (e.g., dual eligible, general assistance, charity care, HMO days, etc.)[60]

The Provider describes a very vague, *generic* SSI Percentage issue that essentially alleges a lack of access to data without identifying any particular errors in the calculation of the SSI percentage at issue. When considering the specificity of the "contents" requirements in 42 C.F.R. § 405.1835(b), the Board finds the Provider's issue statement in the request for hearing to be deficient because it failed to meet the "contents" requirements in subsection (b)(2). More specifically, this issue statement generically refers to certain "histocial[] inaccuracies" in the SSI calculation, but fails to include any description of the alleged "historical[] inaccuracies" (*e.g.*, describe a mechanical implementation error or a statutory interpretation error) much less explain "*why* . . . Medicare payment is incorrect for *each* disputed item" or "*how* and *why* Medicare payment must be determined differently for *each* disputed item." Similarly, it fails to comply with Board Rule 8.1: "to *specifically identify* the items in dispute" and describe each item "as narrowly as possible." The Board notes that, by the time the Provider filed its request for hearing *in February 2015*, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentages:

> 1. *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. 2006-D20 (Mar. 17, 2006), *rev'd by* CMS Adm'r Dec. (May 11, 2006).
>
> 2. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
>
> 3. CMS Ruling 1498-R (April 28, 2010); and
>
> 4. 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010) (adopting a new data matching process post *Baystate* that, among other things, restated CMS' policy that SSI entitlement is based on only 3 specified SSI PSCs).
>
> 5. *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914 (D.C. Cir. 2013) (reviewing the agency's interpretation of the

[60] Board Rule 8 (March 1, 2013 & July 1, 2015) (italics and underline emphasis added).

> phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*, 657 F.3d 1 (D.C. Cir. 2011) found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase (718 F.3d at 920)).

However, ***none*** of these documents nor the detailed alleged errors or issues described within these documents are referenced in the request for hearing. Similarly, unlike the Provider's description of the SSI Percentage issue, the group issue statement is very specific:

> The Providers dispute CMS's position that only Dual Eligible Days, and DE MNC Days, that are also SSI Days go in the Medicare numerator of the DSH calculation. Since Medicare interprets "entitled" to Medicare as "eligible" for Medicare, and thus their basis for including these days in the Medicare ratio, then they must interpret 'entitled" to SSI as "eligible" for SSI which includes days where the patient may only be receiving their SSI medical benefit/Medicaid, to be include dint eh DSH Medicare numerator.

Thus, the Board concludes that the Provider's description of its SSI Percentage issue does not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing. In particular, it for failure to satisfy individually the requirements for a Board hearing under 42 C.F.R. § 405.1835(a)-(b) for the group issue.

Based on the above findings, the Board ***dismisses*** Participant No. 7 in Case No. 17-1408G (University of Wisconsin Hospitals, Prov. No. 52-0098, FYE 6/30/2010), for failure to appeal the group issue as well as the issue for which EJR has been requested. Since jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies this Participant's request for EJR.[61]

4. Case No. 18-0329G – Issue Not Appealed by Participant No. 3 (Memorial Healthcare, Prov. No. 23-0121, FYE 12/31/2011)

With respect to Participant No. 3 in Case No. 18-0329G (Memorial Healthcare, Prov. No. 23-0121, FYE 12/31/2011), the Board hereby ***dismisses*** the Provider from the case because the issue that was appealed and then transferred from the Provider's individual case under Case No. 15-1978 to Case No. 18-0329G was ***not*** the issue for which EJR has been requested in Case No. 18-0329G.

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[61] *See* 42 C.F.R. § 405.1842(a).

On April 6, 2018, the Provider filed a request to transfer its "DSH SSI Fraction Dual Eligible Days" issue (to which Audit Adjustment No. 27 was designated as relevant) from its individual appeal to Case No. 18-0329G. Audit Adjustment No. 27 was "[t]o correct SSI Rates and DSH allowable Rate." The complete description of the "DSH SS Fraction Dual Eligible Days" issue in this Provider's individual appeal was:

> ***Medicaid* Fraction – Exhaust** [*sic*] **days**
>
> Statement of the Issue:
>
> The intermediary *erred by incorrectly omitting days* attributable to patients whose benefits were exhausted for Medicare Part A which Medicare Part A did not make payment and were dual eligible for Medicaid and Medicare for purposes of the calculation of the provider's disproportionate share payment.
>
> Brief Description of the Issue
>
> The Provider believes the intermediary's calculation of the Providers' Medicare disproportionate share hospital (DSH) payments *improperly excluded "exhausted benefit days" in the Medicaid fraction numerator*. These would include days attributable to patients whose benefits were exhausted for Medicare Part A which Medicare Part A did not make payment and where the patient was dual eligible for Medicaid and Medicare as described in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Audit Adjustment Numbers:
>
> *Audit Adjustment number 27*
>
> Amount in Controversy:
>
> The Provider believes that its DSH reimbursement *should correctly adjust the "Medicaid fraction"* to include days attributable to patients whose benefits were exhausted for Medicare Part A which Medicare Pat A did not make payment and where the patient was dual eligible for Medicaid and Medicare. The correct value of this adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to the calculation of the adjustment to the DSH payment are, to the best of the Provider's knowledge, in the possession of CMS.

> Legal Basis for Appeal:
>
> The Provider believes that inclusion of the requested days for purposes of the disproportionate share hospital (DSH) payment is supported by the plain language of 42 U.SC. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[62]

On April 8, 2020, the Medicare Contractor filed a jurisdictional challenge, arguing that the only "Exhausted Days" issue appealed by the Provider related to the ***Medicaid*** Fraction, and not the ***SSI*** Fraction (which is at issue in the instant appeal). As such, it argues that this Provider should be dismissed for failing to timely appeal the relevant issue that is the subject of the EJR request.[63]

The Provider filed a response on May 8, 2020 and counters that, while its issue statement for the Exhausted Days issue focused on the Medicaid Fraction, its "*overarching*, ***primary*** argument is the 'omission of dual eligible days . . . in the provider's Medicare disproportionate payment', which encompasses both fractions . . . ."[64] The Provider also contends that the group issue statement can be inferred from other portions of its appeal statement: "When you read through the Providers' full Appeal Issue Statement you see the discussion about Dual Eligible and SSI Days, and multiple references to 'SSI Days', at least six (6) times, and quickly see the connection the Providers make many times between Dual Eligible and SSI patients, and that Dual Eligible patients are a proxy for the Medicare SSI patients who were *wrongfully* ***excluded from the Medicare numerator*** *by CMS's narrow construction of the statutory 'entitlement to SSI' requirement*."[65]

The Board disagrees with the Provider and finds that the issue in the EJR request is a different from the "*Medicaid* Fraction – Exhaust [*sic*] days" issue appealed by the Provider (as quoted above). The group issue as reflected in the EJR request is asserting that CMS improperly ***under***counted SSI days in the ***SSI*** or Medicare fraction by too narrowly defining "entitled to SSI benefits" and, as such, this is solely an SSI fraction issue and does not involve the Medicaid fraction. In contrast, the "*Medicaid* Fraction – Exhaust [*sic*] days" issue in the individual appeal is solely focused on counting Medicare Exhausted days in the ***Medicaid*** fraction and to that end only cites to the DSH statutory provision governing the Medicaid fraction: 42 U.SC. § 1395ww(d)(5)(F)(vi)(II).

The Provider tries to assert that, because it mentions "SSI fraction" elsewhere in its appeal request and also refers to "SSI days" elsewhere, this should be sufficient to preserve its appeal rights on the SSI entitlement issue laid out in the EJR request. The Provider is mistaken and their "primary, overarching argument" about CMS' alleged improper interpretation of SSI entitlement is no where to be found in the Provider's individual appeal. The Provider's appeal request had 2

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[62] (Italics emphasis added.)
[63] Case No. 18-0329G, Medicare Administrative Contractor's Jurisdictional Challenge, 6 (Apr. 8, 2020).
[64] Case No. 18-0329G, Jurisdictional Reply Brief in Response to MAC Jurisdictional Challenge, 3 (May 8, 2020) (emphasis added).
[65] *Id.* (emphasis added).

other issues – "Medicare Advantage Days" relating to the Medicare and Medicaid fractions and a "Medicare Fraction – SSI Percentage" issue. The Medicare Advantage Days issue clearly *only* argued for movement of Medicare Advantage Days ***from*** the Medicare fraction ***to*** the Medicaid fraction (*i.e.*, increasing the Medicaid fraction and decreasing the Medicare fraction).[66]

The Provider's contention also does not bear out with the "Medicare Fraction – SSI Percentage" issue. The description for the "Medicare Fraction – SSI Percentage" issue in the Provider's individual appeal was:

> Statement of the Issue:
>
> The intermediary ***erred*** by incorrectly calculating the SSI percentage for inclusion in the "Medicare fraction" for purposes of the calculation of the provider's disproportionate share payment.
>
> Brief Description of the Issue
>
> The Provider believes the Intermediary's calculation of the Providers' [sic] Medicare disproportionate share hospital (DSH) payments contains ***errors*** in the calculation of the SSI percentage for purposes of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).
>
> Audit Adjustment Numbers:
>
> Audit Adjustment numbers 27 and 48
>
> Amount in Controversy:
>
> The Provider believes that its DSH reimbursement should correctly reflect an accurate SSI percentage for purposes of the "Medicare fraction". The correct value of this adjustment is not able to be fully calculated from the information currently available to the provider, but is in excess of $10,000. The documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation as required by

[66] This is brought home by the Provider's description of the issue as it relates to the Medicare fraction: "The Provider believes the Intermediary's calculation of the Provider's Medicare disproportionate share hospital (DSH) payments ***improperly included*** days attributable to patients with Medicare Part C (Medicare Advantage) in the denominator and ***improperly included*** patients eligible for both SSI and Medicare Part C *in the numerator of the* ***Medicare*** *fraction* as described in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)." Similarly, the Provider describes the issue as it relates to the Medicaid fraction: "The Provider believes the Intermediary's calculation of the Providers' Medicare disproportionate share hospital (DSH) payments ***improperly omitted*** days attributable to patients who were dually eligible for Medicare Advantage and Medicaid *from the numerator of the "****Medicaid*** *fraction"* described in 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b)." (Emphasis added.)

> DHS are, to the best of the Provider's knowledge, solely in the possession of CMS.
>
> Legal Basis for Appeal:
>
> The Provider believes that inclusion of ***correct*** data and calculation of the SSI percentage for purposes of the disproportionate share hospital (DSH) payment is supported by the plain language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II) and 42 C.F.R. § 412.106(b).[67]

For the same reasons outlined in Section V.B.3., *supra*, the Board finds that this issue statement does not comply with 42 C.F.R § 405.1835(b) or Board Rule 8.1. Under 42 C.F.R. § 405.1835(b)(2) (2013). The Board notes that this issue statement in the Provider's individual appeal is slightly different than the statement discussed in Section V.B.3., *supra*, but not in any material way. The vague reference to "inclusion of correct data" in the "Legal Basis for the Appeal" section does nothing to cure the deficiencies. Similarly, the vague reference in the "Amount in Controversy" section of this specific issue to certain documents solely in CMS' possession does nothing to cure the deficiencies (particularly when the very issue that is the subject of the EJR is a legal issue). Specifically, Providers' inability to calculate the amount in controversy because "documents or data relating to CMS's calculation of the adjustment to the DSH payment that were utilized in CMS's calculation of the adjustment . . . are, to the best of the Provider[s'] knowledge, solely in the possession of CMS" does nothing to cure this deficiency.[68] For the same reasons outlined above, the Board concludes that the Provider's description of its SSI Percentage issue does not comply with the regulatory specificity requirements (or related Board Rules) mandated for a Board hearing.[69]

Based on the above findings, the Board ***dismisses*** Participant No. 3 in Case No. 18-0329G (Memorial Healthcare, Prov. No. 23-0121, FYE 12/31/2011), for failure to appeal the group issue as well as the issue for which EJR has been requested. Since jurisdiction over an appeal is

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[67] (Bold and italics emphasis added.)

[68] The Board further notes that 42 C.F.R. § 405.1835(b) requires the RFH appealing a specific item to explain the following per paragraph (1)(i): "Why the provider believes Medicare payment is incorrect **for each disputed item** (*or*, where applicable, ***why*** *the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment*)." (Emphasis added.) Accordingly, if the provider does not have access to underlying information concerning the calculation of the its payment, the regulation requires the provider to explain "why the provider is unable to determine Medicare payment is correct." Here, because the Provider's issue (as described in the EJR request) is a legal one based on interpretation of the relevant statute and regulations, the Provider was able to determine that the payment was incorrect but may or may not have been able to quantify the amount of incorrectness.

[69] The Board notes that the issue statement for the optional group case here is virtually the same as that for the group case relevant in Section V.B.3, *supra*. Thus, unlike the Provider's description of the SSI Percentage issue, the group issue statement is very specific Similarly again, the Board notes that, by the time the Provider filed its request for hearing *in March 2015*, there had been much litigation and several Agency publications describing certain systemic errors in the data matching process used to calculate SSI percentages. *See* Section V.B.3, *supra*.

a prerequisite to granting a request for EJR, the Board hereby denies this Participant's request for EJR.[70]

5. Case No. 17-1771G – Issue Not Appealed by Participant No. 5 (Bryan Medical Center, Prov. No. 28-0003, FYE 5/31/2012)

With respect to Participant No. 5 in Case No. 17-1771G (Bryan Medical Center, Prov. No. 28-0003, FYE 5/31/2012), the Medicare Contractor filed a jurisdictional challenged on November 20, 2018. The description of the issue in this Provider's individual appeal (Case No. 17-0821) was, in pertinent part:

> ***Understatement of Medicare disproportionate share (DSH) reimbursement***
>
> The MAC improperly accounted for certain types of patient days in calculating the Medicare DSH adjustment. The types of days at issue include but are not limited to, SSI days and Medicare Part C days, as further explained below.
>
> ***
>
> **SSI Days** – The MAC failed to correctly calculate the Medicare fraction of the Medicare DSH calculation. The computation of the SSI fraction for the year(s) at issue is incorrect due to systemic errors in both the method and execution of the MAC's calculations and has resulted in an ongoing understatement of the Medicare DSH payments owed by the Government to the Provider in this appeal. The methodological errors include, among others, instances in which the MAC failed to include all required "SSI" days in the numerator.
>
> ***
>
> Given the foregoing errors, the MAC's calculations were inconsistent with the Congressional intent to reimburse hospitals for treatment of all indigent patients when determining DSH program eligibility and reimbursement.
>
> ***
>
> The SSI Days issue is also a challenge to the Secretary's underlying policy. This is because CMS calculates the SSI

[70] *See* 42 C.F.R. § 405.1842(a).

> adjustment in its sole discretion; the MAC does not change or modify that calculation.[71]

In its jurisdictional challenged, the Medicare Contractor argued that the SSI Dual Eligible Days issue was not appealed in the Provider's individual appeal. It argues that the only issue appealed there was that the calculation of the Provider's Medicare DSH payments contains errors in the calculation of the SSI percentage, which is a different issue that does not address Dual Eligible Days as a basis for appeal with respect to the SSI ratio.[72]

On August 4, 2021, the Provider filed a response to this challenge, arguing that:

> Bryan Medical Center expressed clear dissatisfaction with the exclusion of SSI patient days from the numerator of its Medicare Fraction. Bryan Medical Center even explained that this exclusion was both methodological and executional errors (also sometimes referred to as mechanical data matching error), and further that the methodological or policy errors included "among others" failure to include "all required 'SSI' days" due to CMS's conflicting interpretation of "entitlement".[73]

The Board disagrees with the Medicare Contractor. While the Provider' issue statement does not contain an abundance of clarity, the Board believes that, unlike the two situations discussed previously in Sections V.B.3 and V.B.4, it includes enough specificity (as noted by the emphasis added in the above excerpts) to confirm that the Provider's issue statement in its RFH includes a challenge to the Secretary's ***policy*** on SSI days which is to interpret "entitled to [SSI] benefits"[74] to include only ***paid*** SSI days when determining what SSI days to include in the numerator of the SSI fraction as set forth in the FY 2011 IPPS final rule. This is highlighted by the fact that, similar to SSI days, the Provider alleges that CMS "improperly accounted" for Medicare Part C days by an improper statutory interpretation of "entitled" and that this was contrary to Congressional intent.[75]

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[71] (Underline emphasis added.) The Provider also appealed two other aspects of the DSH payment not subject to the instant EJR request: Medicare Part C/Part A days Medicare Fraction, and Medicare Part C/Part A days Medicaid Fraction.

[72] PRRB Case No. 17-1771G, Medicare Administrative Contractor's Jurisdictional Challenge, 4 (Nov. 20, 2018).

[73] PRRB Case No. 17-1771G, Response to Appeals Support Contractor's Jurisdictional Challenge, 5 (Aug. 4, 2021).

[74] 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I).

[75] With respect to Part C, the Provider's issue statement states, in part: "A patient who received Medicare benefits for a particular patient day under the Medicare + Choice/Medicare Advantage program (Medicare Part C) is not 'entitled' to receive Medicare A benefits for the same patient day. That is the case because the Part C enrollee is not entitled to have payment made under Part A for those days covered by the Part C plan. The DSH calculation for the year(s) at issue was calculated incorrectly because the MAC treated Part C enrollees as 'entitled to Medicare Part A benefits.' The MAC thus erroneously excluded the Part C patient days from the numerator of the Medicaid fraction." *See also* reference to Part C days in the except accompanying *supra* note 71.

C. Analysis Regarding the Appealed Issue

As noted above, the Secretary revised the SSI data match process in light of the *Baystate* decision through notice and comment in the form of an uncodified regulation. First, the Secretary issued CMS Ruling 1498-R on April 28, 2010, authorizing remands of pending appeals of the SSI data match issue to recalculate the SSI fraction based on a revised data match.[76] The Secretary also stated in the ruling that, where cost reports had not been settled, those providers SSI fraction would be calculated using the revised data match.[77] Contemporaneous with CMS Ruling 1498-R[78] the Secretary published a proposed IPPS rule[79] which proposed to adopt the same data match for 2011 and forward. This proposed rule was adopted as the 2011 Final IPPS Rule in which the Secretary explained that:

> . . . we used a revised data matching process . . . that comports with the court's decision [in *Baystate* to recalculate the hospitals SSI fractions]. As the revised data matching process was completed using SSI eligibility data compiled between 13 and 16 years beyond the fiscal years at issue in the *Baystate* case, we believe any issues associated with retroactive determinations of SSI eligibility and the lifting of payment suspensions had been long since resolved. Furthermore, because we believe that the revised match process used to implement the *Baystate* decision addressed all of the concerns found by the court, in the FY 2011 IPPS/LTCH PPS proposed rule we proposed to use the same revised data matching process for calculating hospitals' SSI fractions for FY 2011 and subsequent fiscal years.[80]

Then she announced that:

> We have adopted the proposed data matching process for FY 2011 and beyond as final. The only modification we are making to the proposed matching process is adopting a policy to exclude a record from the data matching process if we find a HICAN in the MedPAR file that we are not able to locate in the EDB[81]which is an extremely unlikely situation as noted in the prior discussion in this final rule. We are adopting this additional step in our validation process to respond to public comment and provide even more assurances that our data matching process will yield accurate SSI fractions and capture all Medicare beneficiaries who were

[76] CMS Ruling 1498-R at 27.
[77] *Id.* at 31.
[78] *Id.* at 5.
[79] 75 Fed. Reg. 23,852, 24,002-07.
[80] 75 Fed. Reg. at 50,277.
[81] (Medicare) Enrollment Database.

> entitled to SSI at the time of their inpatient hospital stay. The same data matching process will be used to calculate SSI fractions for cost reporting periods covered under the ruling.[82]

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

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as "Uncodified SSI Data Match Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[83]

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

VI. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the participants in these group appeals are entitled to a hearing before the Board, ***except for*** the following:

    a. Participant No. 4 in Case No. 17-1771G (Memorial Healthcare, Provider No. 23-0121, FYE 12/31/2012) as the Board previously issued a decision in Case No. 16-0023 denying transfer of its SSI/DSH issue to Case No. 17-1771G;

    b. Participant No. 7 in Case No. 17-1408G (University of Wisconsin Hospitals, Prov. No. 52-0098, FYE 6/30/2010 for failure to satisfy individually the requirements for a Board hearing under 42 C.F.R. § 405.1835(a)-(b) and related Board Rules for the group issue; and

---

[82] 75 Fed. Reg. at 50,285.

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

c. Participant No. 3 in Case No. 18-0329G (Memorial Healthcare, Prov. No. 23-0121, FYE 12/31/2011 for failure to satisfy individually the requirements for a Board hearing under 42 C.F.R. § 405.1835(a)-(b) and related Board Rules for the group issue.

2) Based upon the participants' assertions regarding FY 2011 Final IPPS Rule there are no findings of fact for resolution by the Board;

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

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

Accordingly, the Board finds that the question of the validity of validity of the Uncodified SSI Data Match Regulation (as adopted in the preamble to the 2011 Final IPPS Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR (except as noted above) for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

12/21/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Danene Hartley, National Government Services, Inc.
Byron Lamprecht, WPS Government Health Administrators
Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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410-786-2671

Via Electronic Delivery

Erik Volk
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Spokane, WA 99201

RE: ***Notice of Dismissal***
Mason General Hospital (Prov. No. 50-1336)
FYE 12/31/2011
Case No. 15-3399

Dear Mr. Volk:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Mason General Hospital's ("Provider") Individual Appeal Request on appeal on August 27, 2015, appealing from a Revised Notice of Program Reimbursement ("RNPR") dated March 4, 2015. The sole issue appealed is the disallowance of Electronic Health Records ("EHR") costs, which is the basis for claiming an HER Incentive program payment. The Provider filed a Preliminary Position Paper ("PPP") on April 29, 2016, and the Medicare Contractor filed its PPP on August 29, 2016.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 remains in effect.

The Board issued a Notice of Hearing on September 22, 2020 which set a due date for Provider's Final Position Paper ("FPP") of February 26, 2021, which was never filed. On July 21, 2021, the Medicare Contractor filed a Jurisdictional Challenge in this case; the Provider has not filed any response.

On November 1, 2021, Board staff reached out to the parties to request an update on whether the Provider was still pursuing its case since it has not filed its FPP or a response to the Jurisdictional Challenge. After receiving no response, the Board staff followed up on November 8, 2021; however, the representative has yet to respond.

In light of the foregoing, the Board issued a Notice of Potential Dismissal ("Notice") on November 29, 2021. The Notice required the Provider's Representative to advise whether the Provider is still pursuing this appeal within fifteen (15) days of the Notice. The Board noted that the filing deadline imposed by the Notice was specifically exempt from Board Alert 19's suspension of Board filing deadlines. Furthermore, the Board stated that failure of the Provider to respond by the filing deadline "will result in the dismissal of this case." The Board has received no further update or response to the Notice since its issuance.

Board Rule 41.2 (July 1, 2015) 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 <u>unable</u> to contact the provider or representative at the last known address, or***
- upon failure to appear for a scheduled hearing.[1]

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 its Position Paper 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;

[1] (Emphasis added.)

> (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

Similarly, the Board's Rules further emphasize the need for the parties to meet filing deadlines. Rule 23.1 states, in pertinent part:

> To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:
>
> - Jointly agree to a proposed Joint Scheduling Order (JSO) . . . or,
> - If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.
>
> **Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.**[2]

Rule 23.3 is accompanied with a heading that reads "Preliminary Position Papers Required if no Proposed JSO is Executed" and explains:

> If the parties do not jointly execute and file a proposed JSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file

[2] (Emphasis in original.)

> preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

Rule 23.4, "Failure to Timely File" further states:

> The Provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, **the case will be dismissed**.[3] If the Intermediary fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.
>
> Finally, Rule 23.5 related to extension requests for Preliminary Position Papers and the associated commentary states that an extension **must** be filed at least three weeks before the due date and will only be granted for good cause.

Based on the failure of the Provider's Representative to respond to any of the Board's direct inquiries and the lack of any contact with the Board since filing is Preliminary Position Paper in 2016 (including but not limited to responding to the Notice of Hearing, Jurisdictional Challenge, or Notice of Potential Dismissal), the Board hereby dismisses Case Number 15-3399 and removes it from its docket.

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

Board Members:

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

For the Board:

12/30/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
John Bloom, Noridian Healthcare Solutions

[3] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
UHHS CY 2018 & 2019 DGME CIRP Groups
Case Nos. 20-1839GC, 22-0126GC

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' December 10, 2021 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[1]

Background

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> Add the two products to determine the hospital's reduced cap.[12]

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

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

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

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

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

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

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.

---

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

Providers' EJR Request:

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

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[19] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[20] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[21]

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

Third, in some situations, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap. The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

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

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[17] Providers' Consolidated Petition for Expedited Judicial Review at 1 (Dec. 10, 2021) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[18] *Id.* at 8-9.
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[21] *Id.* at § 1395(h)(4)(F)(i).
[22] PRRB Rule 42.4 (v. 3.1, 2021).

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

A. Board Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- Each request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [23]
- The matter at issue involves single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy for the group is $50,000 or more.[24]

The Medicare Contractor has not filed any jurisdictional challenge or noted any jurisdictional impediments since the receipt of the initial appeal and the Providers' EJR Request.

Further, the Board notes that, pursuant to the final rule in the Federal Register on November 13, 2015 and effective January 1, 2016 for cost reporting periods beginning on or after January 1, 2016,[25] the Secretary: "[A]dopt[ed] [her] proposal to eliminate our interpretation (in §§ 405.1835(a)(1) and 405.1840(b)(3)) that a provider must make an appropriate cost report claim for an item *in order to meet* ***the dissatisfaction requirement for Board jurisdiction*** *over appeals* of a timely final contractor determination or Secretary determination."[26] As a result, making a specific claim (whether for reimbursement or protest) on the as-filed cost report for the issue being appealed is no longer needed to meet the dissatisfaction requirement for Board jurisdiction over an appeal of that issue.

In each of these two cases, there are only two participants. Only one of these participants (UHHS Richmond Heights Hospital in Case No. 20-1839GC) filed from an original NPR and timely an appeal request to be directly added to the relevant group. The remaining three participants filed appeal request from the failure to issue a timely determination and similarly

[23] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[24] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[25] 80 Fed. Reg. 70298 (Nov. 13, 2015).
[26] *Id.* at 70571 (emphasis added).

timely filed the appeal requests as requests to be directly added to the relevant group. The regulation at 42 C.F.R. § 405.1835(c) permits a provider to file an appeal with the Board where:

> (1) A final contractor determination for the provider's cost reporting period is not issued (through no fault of the provider) within 12 months after the date of receipt by the contractor of the provider's *perfected cost* report or amended cost report (as specified in § 413.24(f) of this chapter). The date of receipt by the contractor of the provider's perfected cost report or amended cost report is presumed to be the date the contractor stamped "Received" on such cost report unless it is shown by a preponderance of the evidence that the contractor received the cost report on an earlier date.
>
> (2) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request is no later than 180 days after the expiration of the 12 month period for issuance of the final contractor determination (as determined in accordance with paragraph (c)(1) of this section) . . .[27]

In both cases, the claimed amount in controversy exceeds the $50,000 threshold to establish the group. Further, Board review of the DGME issue is not precluded by statute or regulation. Accordingly, the Board concludes that it has jurisdiction over the DGME issue for all participants as well as jurisdiction over both CIRP groups.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873

The 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.[28] Specifically, effective January 1, 2016, the Secretary enacted both 42 C.F.R. §§ 413.24(j) and 405.1873. The regulation at § 413.24(j)(1) specifies that, in order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, a provider must include an appropriate claim on its cost report by either claiming the item in accordance with Medicare policy or self-disallow the specific item in the cost report if it believes it may not be allowable.[29]

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

[27] (emphasis added).
[28] 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").
[29] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

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"[30] 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.[31] In this case, the Provider filed its EJR request on December 10, 2021 and, under Board Rule 44.5.1 (effective November 1, 2021), the Medicare Contractor had five (5) days from that filing failed to submit a Substantive Claim Challenge[32] but failed to do so within that time frame.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[33] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered and no findings needed be made on compliance with § 413.24(j). Accordingly, the Board may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. Board's Analysis of the Appealed Issue

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

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}$$ [34]

[30] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[31] *See* 42 C.F.R. § 405.1873(a).
[32] As noted at Board Rule 44.5, "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[33] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44." Additionally, since the Providers filed their EJR request prior to filing their preliminary position papers, the deadline for the Medicare Contractor to submit a Substantive Claim Challenge on the issue that is the subject of the EJR must have been filed within five days of the EJR Request pursuant to Board Rule 44.5.2 (v.3.1, 2021). The request for EJR also included PRRB Case 19-1720GC, but the Medicare Contractor has filed a notice that a substantive claim challenge is forthcoming in that case. This permits additional time for the Medicare Contractor to file its Substantive Claim Challenge pursuant to Board Rule 44.6 (v.3.1, 2021).
[34] EJR Request at 4.

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.[35] 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.[36] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[37]

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.[38] Indeed, CMS reiterates this in

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[35] *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.)).
[36] 66 Fed. Reg. at 39894 (emphasis added).
[37] (Emphasis added.)
[38] *See* 62 Fed. Reg. at 46005 (emphasis added).

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."[39] 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[40] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[41]

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:

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

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[39] *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.)).

[40] 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.

[41] 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.

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

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

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in both cases, the Board hereby closes the cases. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

12/30/2021

X Clayton J. Nix

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

Enclosures: Schedules of Providers

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Emily Sun
Grace Home Healthcare, LLC
9735 Main Street, Suite 200
Fairfax, VA 22031

RE: ***Notice of Dismissal***
Grace Home Healthcare, LLC (Prov. No. 49-7754)
CY 2020
Case No. 20-0705

Dear Ms. Sun:

The Provider Reimbursement Review Board ("Board" or "PRRB") issued a Notice of Potential Dismissal to the Provider on November 23, 2021. The Board ordered that the Provider's Representative respond within 15 days to advise the Board whether the Provider is still pursuing this appeal. The Board Notice advised the Provider that the deadline was ***exempt*** from Alert 19's suspension of Board filing deadlines and further stated, "Accordingly, failure of the Provider to respond by the above filing deadline *will result in the* ***dismissal*** *of this case*."[1] To date, no response has been received by the Board and the Board.

As noted in the Notice of Potential Dismissal, 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 <u>unable</u> to contact the provider or representative at the last known address, or***
- ***upon failure to appear for a scheduled hearing.***[2]

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.

[1] (Emphasis added.)
[2] (Emphasis added).

> (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 its Position Paper 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.

Based on the failure of the Provider's Representative to respond to any of the Board's direct inquiries and the lack of any contact with the Board following the filing of the appeal (including but not limited to responding to the two separate Critical Due Dates Notice and the Notice of Potential Dismissal), the Board hereby dismisses this appeal pursuant to its discretion under Board Rule 41.2 and closes Case No. 20-0705. The case is hereby removed from the Board's docket.

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

Board Members:

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

For the Board:

12/30/2021

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Judith Cummings, CGS Administrators (J-15)