DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
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RE: ***Jurisdictional Decision***
Sycamore Shoals Hospital (44-0018)
FYE 06/30/2013
Case No. 16-1717

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced appeal pursuant to a jurisdictional challenge filed by the MAC. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

Sycamore Shoals Hospital, appealed an original Notice of Program Reimbursement ("NPR") dated November 23, 2015, for its fiscal year end ("FYE") June 30, 2013 cost reporting period. On May 23, 2016, the Provider filed an individual appeal request which contained the following issues including those challenged by the MAC below.[1]

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Part C Days – SSI Fraction
- Issue 4: DSH Dual Eligible Days – SSI Fraction
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicare Part C Days – Medicaid Fraction
- Issue 7: DSH Dual Eligible Days – Medicaid Fraction
- Issue 8: Outlier Payments – Fixed Loss Threshold[2]

On January 16, 2017, the Provider transferred issues 2, 3, 4, 6, 7, and 8 to groups, and issue 5 was withdrawn on October 4, 2018.[3] Issue 2, DSH Systemic Errors, was transferred to PRRB Case

[1] Provider's Request for Hearing, Tab 3, at Issue Statement (May 23, 2016).
[2] *Id*.; MAC's Jurisdictional Challenge, at 1 (Dec. 29, 2021) (Issues 2 through 8 were either transferred or withdrawn to various group cases).
[3] MAC's Jurisdictional Challenge, at 1.

No. 16-2037GC.[4] After transfers and withdrawals, Issue 1 is the sole remaining issue.

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[5]

Similarly, the Provider described Issue 2, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case No. 16-2037GC, as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider further contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records;
> 2. Paid days vs. Eligible Days;

[4] *Id*.
[5] Individual Appeal Request, Issue 1.

3. Not in agreement with provider's records;
4. Fundamental problems in the SSI percentage calculation;
5. Covered days vs. Total days; and
6. Failure to adhere to required notice and comment rulemaking procedures.[6]

On December 29, 2021, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor, regarding Issue No. 1 which addressed the DSH Supplemental Security Income ("SSI") Percentage (Provider Specific) issue.[7] The Medicare Contractor contends Issue 1 should be dismissed from this case. According to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. As noted above, the Provider transferred Issue 2 to Group Case No. 16-2037GC, "*QRS MSHA 2013 DSH SSI Percentage CIRP Group*." The Medicare Contractor contends that the portion of Issue 1 related to SSI Data accuracy should be dismissed because it is duplicative of the issue under appeal in Group Case No. 16-2037GC. The Medicare Contractor also argues that the Board should dismiss the portion related to SSI realignment because there was no final determination over SSI realignment and the appeal is premature, as the Provider has not exhausted all available remedies.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2013), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

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

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

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

A. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider's disagreement with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group case no. 16-2037GC, "*QRS MSHA 2013 DSH SSI Percentage CIRP Group*.[8]

[6] *Id* at Issue 2.
[7] MAC's Jurisdictional Challenge, at 1 (Jan. 13, 2020).
[8] *See* Request to Transfer Issue, Model Form D (Jan. 18, 2017), PRRB Case No. 16-1717.

The DSH SSI Percentage (Provider Specific) issue in the present appeal concerns:

> …the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.[9]

The Board finds that the first aspect of Issue 1 (the DSH/SSI (Provider Specific) issue) in this appeal is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue) which was transferred to Case No. 16-2037GC. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2, transferred to the Group Case No. 16-2037GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, and that the DSH/SSI Percentage is improper due to a number of factors, and that the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 which was transferred to Group Case No. 16-2037GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In arriving at this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, it is proper to pursue that issue as part of the group under Case 16-2037GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[13] Provider is in error in referring to Issue 1 as "Provider Specific" and including it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged

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[9] Provider's Request for Hearing, Tab 3, at Issue Statement, Issue 1 (May 23, 2016).
[10] Individual Appeal Request, Issue 2.
[11] *Id.*
[12] *Id.*
[13] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

"systemic" issue rather than being subsumed into the "systemic" issue which is being appealed in Group Case No. 16-2037GC.

Accordingly, the Board finds that Issues 1 and 2, which was transferred to Group Case 16-2037GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

B. Second Aspect of Issue 1

The Board finds that the second aspect of the DSH SSI (Provider Specific) issue involves the Provider's request to preserve its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. Under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . . ." The Provider has not requested to have its SSI percentage realigned in accordance with 42 C.F.R. § 412.106(b)(3). Thus, the Provider has not exhausted all available remedies for this issue. Accordingly, the second aspect of Issue 1 is exhausted and the Board dismisses it from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. As there are no more pending issues in the appeal, Case No. 16-1717 is hereby closed and removed from the Board's docket.

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

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
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For the Board:

2/3/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
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Via Electronic Delivery

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RE: ***EJR Determination***
UHHS CY 2016 Incorrect DGME cap & weighting for residents beyond IRP CIRP Grp.
Case No. 19-1720GC

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' December 10, 2021 request for expedited judicial review ("EJR") in the above-referenced group appeal as well as the January 20, 2022 EJR filed, as a response to the Board's request for substantive claim comments issued December 30, 2021. The decision of the Board is set forth below.

Issue in Dispute

The Provider's issue statement describes the DGME Penalty issue as follows:

> Brief description of the issue:
>
> Whether the Medicare Administrative Contractor ("MAC") must correct its application of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").
>
> Statement identifying the legal basis for the appeal:
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, id. § 1395ww(h)(4)(C). The Provider disputes the computation of the current-year, prior-year, and penultimate-year weighted DGME FTEs, the three-year FTE average, and the FTE cap as applied to the current fiscal year. CMS's regulation at 42 C.F.R. § 413.79(c)(2) implementing the cap and weighting factors is contrary to the statute because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond

> the IRP and prevents the Provider from claiming FTEs up to its full FTE cap. 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payment consistent with the statute so that the DGME cap is set at the number of FTE residents that the Provider trained in its most recent cost reporting periods ending on or before December 31, 1996, and residents beyond the IRP are weighted at no more than 0.5.[1]

Background

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

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

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

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

A hospital's 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.

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

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

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

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

[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).

[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).

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

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

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

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

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

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

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

> 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.

The Providers' Position

The Providers are requesting the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) which implements 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

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

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

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. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R. § 405.1842(f)(1) (2021), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

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

[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) ("If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request."). The EJR Request was filed on Friday, December 10, 2021, so a response would have been due no later than 11:59p.m. (Eastern Time) Friday, December 17.

- They are dissatisfied with final determinations of the Medicare Contractor;[23]
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [24]
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[25]

In this case, both Providers filed timely appeals from NPRs of the DGME issue and Board review of the subject matter appealed is not precluded by statute or regulation. The claimed amount in controversy in this case exceeds the $50,000 threshold. 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. Accordingly, the Board finds that it has jurisdiction over the appeal and the participants.

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

1. Regulatory Background

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

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

[23] 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." 80 Fed. Reg. 70298, 70571 (Nov. 13, 2015)(emphasis added). 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.

[24] 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).

[25] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

> provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[26]

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,**

[26] (Bold and underline emphasis added.)

> **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**.[27]

These regulations are applicable to the cost reporting period of all participants in these group cases. Position papers have not been filed, but both parties have submitted briefs with regard to whether the impacted Providers included an appropriate cost report claim for the disputed issue.

[27] (Bold and underline emphasis added.)

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

In this appeal both providers have cost reports beginning after January 1, 2016 and are subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[28] 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))"[29] 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.

Following the Providers' December 10, 2021 EJR Request, on December 15, the Medicare Contractor filed a certification, pursuant to Board Rule 44.6 (v. 3.1, 2021) that it would be filing a Substantive Claim Challenge within twenty days following the Providers' EJR request. The Medicare Contractor filed its challenge on December 23, 2021, noting that one of the two providers in the group appeal did not make an appropriate cost report claim for the specific item in dispute (specifically, UH Richmond Heights Hospital). On December 30, 2021, the Board issued a Substantive Claim Challenge Response Scheduling Order which specified that the Providers' Representative had until January 21, 2022 to file a response to the Medicare Contractor's Substantive Claim Challenge.

On January 20, 2022, the Providers' Representative filed its Response to the MAC's Substantive Claim Letter. It plainly admits that UH Richmond Heights Hospital did not protest the DGME fellows issue on its cost report, but also that the protest item requirement of 42 C.F.R. §§ 413.24(j) and 405.1873 is invalid. The Providers' Representative simultaneously filed a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (discussed more fully, below).

Pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that UH Richmond Heights Hospital (Prov. No. 36-0075, FYE 12/31/2016) ***failed*** to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) and notes that this point is uncontested.

With regard to the remaining participant in this appeal, 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

[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] (Emphasis added.)

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, although all of the participants in the group are subject to § 413.24(j), the Medicare Contractor only filed a Substantive Claim Challenge against one participant as discussed above.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made regarding the other remaining participants, the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate cost report claim was made for the other remaining participant. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for the other remaining participant.

3. Second EJR Request: Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

As noted above, when it filed its Response to the Medicare Contractor's Substantive Claim Challenge, the Providers' Representative simultaneously filed a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. The Providers request the Board grant EJR as it relates to 42 C.F.R. §§ 413.24(j) and 405.1873.[32] They claim that these regulations contravene the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in that statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[33] The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[34]

With regard to the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (*on its own motion* or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[35]

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[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] Providers' Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873, 1-2 (Jan 20, 2022).
[33] *Id.* at 9.
[34] *Id.* at 8-9.
[35] *Id.* at 11.

The Medicare Contractor has not filed a response to the EJR Request and the time for doing so has elapsed.[36]

The Board finds that it ***does*** have jurisdiction over the new EJR challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Including a challenge to these regulations prior to the Medicare Contractor's Substantive Claim Letter would have been premature. As discussed above, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[37] 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.[38] Accordingly, a potential challenge to those regulations only became relevant once the Medicare Contractor filed its Substantive Claim Challenges to trigger Board review of compliance with those regulations.

B. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[40] As such, the equation would logically appear to be a

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[36] PRRB Rule 42.4 (v. 3.1, 2021) ("If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request."). The EJR Request was filed on Thursday, January 20, 2022, so a response would have been due no later than 11:59p.m. (Eastern Time) Thursday, January 27.

[37] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

[38] *See* 42 C.F.R. § 405.1873(a).

[39] EJR Request at 4.

[40] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[41] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

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

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

---

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

[41] 66 Fed. Reg. at 39894 (emphasis added).

[42] (Emphasis added.)

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

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

[45] Two alternative ways to express the algebraic principle of equivalent functions include:

If a/b = c/d, then c = (a x d) / b ; and

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

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.[46]

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.

C. Board's Decision Regarding the EJR Requests

The Board finds that:

If a/b = c/d, then c = (a/b) x d.

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

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

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

   - UH Richmond Heights Hospital, Provider Number 36-0075, FYE 12/31/2016;

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

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and*** whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are 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 DGME Penalty issue and the subject years. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

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

FOR THE BOARD:

2/9/2022

X Clayton J. Nix

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

Enclosure: Schedule 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

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

RE: ***Jurisdictional Decision***
Stormont Vail Hospital (Prov. No. 17-0086)
FYE 9/30/2017
Case No. 22-0182

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the December 23, 2021 request for transfer of the DSH SSI Percentage (Provider Specific) issue from the subject appeal to the QRS CY 2017 DSH SSI Percentage (2) Group, Case No. 22-0292G. The Board finds that it does not have jurisdiction over the DSH SSI Percentage (Provider Specific) issue. The background and pertinent facts regarding the SSI issues and the jurisdictional decision of the Board are set forth below.

Background:

On November 24, 2021, the Board received Provider's Individual Appeal Request appealing its June 4, 2021 Notice of Program Reimbursement ("NPR") for fiscal year ending September 30, 2017. The initial appeal contained the six (6) following issues:

1. DSH/SSI (Provider Specific)
2. DSH Medicaid Eligible Days
3. DSH/SSI Medicaid Managed Care Part C Days
4. DSH SSI Fraction Dual Eligible Days
5. DSH Medicaid Fraction Dual Eligible Days
6. IPPS Understated Standardized Payment Amount

On December 23, 2021, the Provider added a seventh issue to the case: DSH SSI Percentage. On the same date, the Provider requested the transfer of both Issues 1 and 7 to Group Case No. 22-0292G. The Provider also requested the transfers of Issues 3 through 6[1] to Group Case Nos. 22-0293G, 22-0294G, 22-0295G and 22-0276G, respectively. Accordingly, DSH Medicaid Eligible Days (Issue 2) is the only issue not transferred remaining in the individual appeal.

[1] Issue 6 was transferred on December 20, 2021. All other transfers were filed on December 23, 2021.

Pertinent Facts re: SSI issues & Transfer Requests

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

> The Provider contends that the MAC did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. §1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[2]

Similarly, the Provider described Issue 7, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 22-0292G, as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider further contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Reports incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:
>
> 1. Availability of MEDPAR and SSA Records
> 2. Paid days vs. Eligible Days
> 3. Not in agreement with provider's records

[2] Issue Statement Document uploaded for Issue 1.

4. Fundamental problems in the SSI percentage calculation
5. Covered days vs. Total days and
6. Failure to adhere to required notice and comment rulemaking procedures.[3]

In reviewing the Provider's request to transfer the DSH SSI Percentage (Provider Specific) issue to the group, Case No. 22-0292G, the Board examined its jurisdiction over the issue to determine if it is duplicative of Issue 7 (the DSH/SSI (Systemic Errors) issue), which was transferred to Case No. 22-0292G. The Board also questioned the portion of Issue 1 pertaining to realignment because (1) the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election, not an appealable Medicare Contractor determination; and (2) appealing this issue is premature since the Provider has not exhausted all available remedies and (3) the Provider's Fiscal Year End Date is the same as the Federal Fiscal Year End, so realignment would not result in any change in the SSI percentage and, therefore, is unnecessary.

Board Decision:

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

The Board finds that it does not have jurisdiction over Issue 1, the DSH/SSI (Provider Specific) issue and, therefore, denies the transfer of this issue to Case No. 22-0292G. This jurisdictional analysis of Issue 1 has two components:

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

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

A. First Aspect of Issue 1

The Board finds that the first aspect of Issue No. 1—the Provider's disagreement with the Medicare Contractor's computation of the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 22-0292G.

[3] *Id* for Issue 7.

The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[4] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[5] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[6] Issue 7, transferred to the group under Case No. 22-0292G, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 7 in Case No. 22-0292G. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Mar. 1, 2013), the Board dismisses this aspect of the DSH/SSI (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is properly pursuing that issue as part of the group under Case No. 22-0292G. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[7] The Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-0292G.

B. Second Aspect of Issue 1

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

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[4] Issue Statement Document uploaded for Issue 1.
[5] *Id.*
[6] *Id.*
[7] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Conclusion:

The Board denies the Provider's request to transfer Issue 1, the DSH/SSI (Provider Specific) issue to Case No. 22-0292G and, dismisses the issue in its entirety from this appeal. Case No. 22-0182 remains open given that another issue, DSH Payment – Medicaid Eligible Days, remains pending.

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

Board Members:

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

For the Board:

2/22/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Geoff Pike, First Coast Service Options, Inc. (J-N)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

L. Ryan Hales
Quorum Health
1573 Mallory Ln., Ste. 100
Brentwood, TN 37027

RE: ***Notice of Dismissal***
Galesburg Cottage Hospital (Prov. No. 14-0040)
FYE 4/30/2014
PRRB Case No. 16-2393

Dear Mr. Hales:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Galesburg Cottage Hospital's ("Provider") Individual Appeal Request on appeal on September 9, 2016, appealing from a Notice of Program Reimbursement ("NPR") dated March 14, 2016. The sole issue remaining is Medicaid Eligible Days. The Provider filed a Preliminary Position Paper ("PPP") on May 1, 2017, and the Medicare Contractor filed its PPP on August 31, 2017.

The Medicare Contractor filed a Jurisdictional Challenge on May 2, 2018 over the Medicaid Eligible Days issue. It argues that the number of additional days in dispute is unknown, that the Medicare Contractor did not render a final determination over the additional days, and that the Provider has no right to appeal the issue since it did not self-disallow the disputed item. The Provider filed a response on June 13, 2018, claiming CMS Ruling 1727-R (issued April 23, 2018) permits their appeal of the Medicaid Eligible Days issue.[1]

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 April 20, 2021 which set a due date for Provider's Final Position Paper ("FPP") of October 30, 2021, which was never filed. A hearing was set for January 28, 2022. On January 6, 2022, the Board Advisor 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. After receiving no response, the Board Advisor followed up on January 13, 2022. To date, the Provider's Representative has not responded to the Board's attempts to obtain an update on this case or its position on the scheduled hearing.

In light of the foregoing, the Board issued a Notice of Potential Dismissal on February 1, 2022. The Notice of Potential Dismissal required the Provider's Representative to advise whether the

[1] The Jurisdictional Challenge has not yet been ruled on by the Board.

Provider is still pursuing this appeal *within fifteen (15) days* of the Notice (*i.e.*, by Wednesday, February 16, 2022). The Board noted that the filing deadline imposed by the Notice of Potential Dismissal 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 of Potential Dismissal since its issuance (either by the deadline or afterwards).

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.[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.
>
> (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

[2] (Emphasis added.)

> appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
>
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or
> (3) Take any other remedial action it considers appropriate.

Board Rule 5.2 addresses the Representative's responsibilities:

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

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.**[3]

[3] (Emphasis in original.)

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 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**.[4] 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.

Here, the Provider's Representative has failed to respond to any of the Board's direct inquiries (formal and informal) and has not had any contact with the Board since filing is response to the Medicare Contractor's Jurisdictional Challenge in June, 2018. In particular, the Board notes that the Representative failed to respond to the Notice of Hearing, Board Advisor inquiries regarding the case status, ***and*** the Notice of Potential Dismissal (which was exempt from Board Alert 19). Indeed, even subsequent to the tolling of the filing deadline, there still has been no response to date to the Notice of Potential Dismissal. Accordingly, the Board hereby dismisses Case No. 16-2393 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
Ratina Kelly, CPA

For the Board:

2/22/2022

X Clayton J. Nix

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

[4] (Emphasis added.)

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