DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nicholas Putnam
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RE: ***Notice of Dismissal – Updated Rationale***
SRG Standardized Amount CIRP Group Cases
Case Nos. 19-0295GC, *et al.* (*see* **Appendix A** listing 97 group cases)

Dear Mr. Putnam:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the ninety-seven (97) above-referenced common issue related party ("CIRP") and optional group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all ninety-seven (97) CIRP and optional group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals because the standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issues in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Strategic Reimbursement Group, LLC ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed six (6) Jurisdictional Challenges covering ninety-seven (97) group cases.[7] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all ninety-seven (97) cases are materially identical and can be considered together.

The group issue statement presented is:

> Whether the Secretary's failure to distinguish between patient discharges and transfers and / or the Secretary's inconsistent treatment of transfers during the development of the standardized amount used by the Secretary

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2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 55 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 39 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

> to calculate the reimbursement for diagnosis related groups ("DRG's") during the implementation of the inpatient prospective payment system ("IPPS"), resulted in an understatement of the Federal DRG Prospective Payment Amounts paid to the Providers in the fiscal year at issue, and an understatement of all inpatient prospective payment system reimbursement elements determined based on the standardized amount, including but not limited to indirect medical education ("IME") payment and disproportionate share hospital ("DSH") payment paid to the Providers in the fiscal year at issue.[8]

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position papers, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial "flat rate" payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[9]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[11] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that

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[8] *E.g.*, Case 19-0295GC, Group Issue Statement at 1 (Nov. 14, 2018).
[9] *E.g.*, PRRB Case No. 19-2095GC, Providers' Preliminary Position Paper at 8-9 (Dec. 1, 2020).
[10] *Id*. at 11-12 (citing 56 Fed. Reg. 43449, 43387 (Aug. 30, 1991) (related to capital PPS) and 60 Fed. Reg. 45791 (Sept. 1, 1995) (related to recalibration of DRG weights to exclude transfers for FY 1996)).
[11] *See id.* at 8 ("[t]he Standardized Amount for the current fiscal year is still based upon the Secretary's original calculation of the Standardized Amount utilizing 1981 data. . .").

certain Standardized Amounts erroneously included transfers. Finally, they argue that the understated Standardized Amounts and their resulting understated Medicare payments produces cost shifting prohibited by 42 U.S.C. § 1395x(v)(1)(A)(i).[12]

B. Jurisdictional Challenges

The Medicare Contractor filed challenges in one hundred (100) different group cases, and the Providers filed a response in each case.[13] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal rests on the fact that each appeal's IPPS payments for the applicable FFY are understated as "[t]he DRG Payment Amount formula for fiscal year 1986, and all years following it, still includes a calculation of the standardized amount with the same embedded Discharge Calculation error."[14] They ask the Board to find it has jurisdiction over these appeals.

The Providers counter the Medicare Contractor by arguing that the plain language of 42 U.S.C. § 1395ww(d)(7)(A) "does not contain any limitation to the administrative or judicial review of the Secretary's determination of the standardized amount. . ."[15] The Providers claim they do not seek to challenge the FFY 1984 or 1985 IPPS payments, and the Providers' challenge is not "inextricably tied" with the budget neutrality adjustment subject to judicial preclusion.[16] The Providers also argue that the Board was in error when it labeled the 1984-1985 budget neutrality adjustments as the "applicable percentage increase", as that term started with fiscal year 1986.[17] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[18]

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[12] *Id.* at 13-14.
[13] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical. *See also* notes 53 and 54.
[14] *E.g.*, PRRB Case No. 19-0295GC, Providers' Response to MAC Jurisdictional Challenge at 3 (Feb. 9, 2024).
[15] *Id*. at 5.
[16] *Id.* at 7.
[17] *Id*. at 15.
[18] *Id.* at 21-22.

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 97 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[19] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[20]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[21] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[22] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[23]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[24] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[25] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital

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[19] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[20] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[21] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[22] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[23] *Id.*
[24] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[25] *Id.* (emphasis added).

> services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[26] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[27] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
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> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
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> *are not greater or less than*—

[26] *Id*. at 39763-64.
[27] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[28]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[29]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient

[28] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[29] (Italics emphasis in original and bold and underline emphasis added.)

> operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[30]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[31] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

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[30] (Italics emphasis in original and bold and underline emphasis added.)

[31] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) ***for fiscal year 1986***, 1⁄2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located

> in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
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> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
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> (XIII) for fiscal year ***1998***, 0 percent,
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> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
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> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
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> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
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> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
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> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[32]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(A) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, ***equal to*** *the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the***

[32] (Emphasis added.)

fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous

> fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
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> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
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> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
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> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective <u>adjusted</u> average standardized amounts <u>computed for the previous fiscal year</u>**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[33]

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[33] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[34]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[35] Thus, the standardized

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> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[34] *E.g.*, PRRB Case 19-0295GC *et al.*, Providers' Response to MACs' Jurisdictional Challenge at 3 ("The DRG Payment Amount formula for fiscal year 1986, and all years following it, still includes a calculation of the standardized amount with the same embedded Discharge Calculation Error.").
[35] *See* **Appendix B.**

amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[36]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[37]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[38] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[39]

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[36] *See supra* note 18 accompanying text.
[37] *See id.*
[38] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").
[39] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[40]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[41]

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[40] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[41] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost.
> It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[42]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--**

[42] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[43]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[44] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized

[43] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[44] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[45]

Accordingly, while the Providers did not appeal the budget neutrality adjustments, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[46]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984

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[45] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[46] *Id.* at 255.

budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[47]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[48]

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[47] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[48] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[49]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of*

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individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

[49] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

*rates **for later years***."[50] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[51]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm that they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather

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[50] *Id.* (emphasis added).
[51] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

they are contesting the base rate calculation of the standardized amount.[52] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[53]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the ***prospectively-set*** standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[54] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those applicable budget neutrality adjustments.[55] Indeed, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality

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[52] *E.g.*, PRRB Case Nos. 19-0295GC, *et al.*, Providers' Response to MACs' Jurisdictional Challenges at 20.
[53] *Id.*
[54] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[55] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[56] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* tied with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[57]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the ninety-seven (97) CIRP group cases listed in **Appendix A**, and hereby closes these ninety-seven (97) group cases and removes them 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:

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For the Board:

3/4/2024

X Clayton J. Nix

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

[56] *See supra* note 39 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[57] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

cc: Danelle Decker, National Government Services, Inc. (J-K)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Judith Cummings, CGS Administrators (J-15)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 11, 2023, the Medicare Contractor filed a challenge to the following twenty-one (21) cases[58] which all share a common lead Medicare Contractor, WPS Government Health Administrators (J-5):

19-2331GC	SSM Health FFY 2019 DRG Understatement CIRP Group
19-2338GC	Mercyhealth FFY 2019 DRG Understatement CIRP Group
19-2342GC	Tower Health FFY 2019 DRG Understatement CIRP Group
19-2442GC	SSM Health CY 2015 DRG Understatement CIRP Group
20-0655GC	SSM Health CY 2016 DRG Understatement CIRP Group
20-0672GC	Mercyhealth CYs 2015 – 2016 DRG Understatement CIRP Group
20-2109GC	Mercyhealth CY 2017 & FFY 2020 Understatement of PPS Standardized Amt. CIRP Group
20-2115GC	SSM Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
20-2116GC	Tower Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-0948GC	Tower Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group
21-1038GC	SSM Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group
21-1074GC	Mercyhealth FFY 2021 Understatement of PPS Standardized Amount CIRP Group
22-0609GC	Tower Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
22-0645GC	SSM Health CY 2017 Understatement of PPS Standardized Amount CIRP Group
22-0655GC	SSM Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
22-0675GC	Mercyhealth FFY 2022 Understatement of PPS Standardized Amount CIRP Group
23-0271GC	SSM Health CY 2018 Understatement of PPS Standardized Amount CIRP Group
23-0571GC	SSM Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-0606GC	Mercyhealth FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-1201GC	Mercyhealth CY 2018 Understatement of PPS Standardized Amount CIRP Group
23-1392GC	Tower Health CY 2019 Understatement of PPS Standardized Amount CIRP Group

On September 13, 2023, the Medicare Contractor filed a challenge to the following forty-four (44) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-6):

19-1469G	Strategic Reimb Group CY 2014 DRG Understatement Group
19-2024G	Strategic Reimb Group CY 2015 DRG Understatement Group
19-2297GC	Hospital Sisters Health CY 2015 DRG Understatement CIRP Group
19-2323GC	Hospital Sisters Health FFY 2019 DRG Understatement CIRP Group
19-2329GC	Sinai Health FFY 2019 DRG Understatement CIRP Group
19-2334G	Strategic Reimb Group FFY 2019 DRG Understatement Group
19-2340GC	Northwestern Medicine FFY 2019 DRG Understatement CIRP Group
19-2784G	Strategic Reimb Group CY 2016 DRG Understatement Group
20-1558GC	Hospital Sisters Health CY 2016 DRG Understatement CIRP Group

[58] PRRB Case No. 19-2443GC was also included in this Jurisdictional Challenge. However, this case was withdrawn on October 12, 2023.

20-1738GC	SSM Health CY 2013 DRG Understatement CIRP Group
20-1739GC	SSM Health CY 2013 Transfer Case Underpayment CIRP Gr
20-1950G	Strategic Reimb Group CY 2014 DRG Understatement Group
20-2105GC	Hospital Sisters Health FFY 2020 Understatement of PPS Standardized Amt. CIRP Group
20-2107G	Strategic Reimb Group FFY 2020 Understatement of PPS Standardized Amount Group
20-2110GC	Northwestern Medicine FFY 2020 Understatement of PPS Standardized Amt. CIRP Group
20-2114GC	Sinai Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-0016GC	Northwestern Medicine CY 2016 Understatement of PPS Standardized Amount CIRP Group
21-0022GC	Hospital Sisters Health CY 2017 Understatement of PPS Standardized Amount CIRP Group
21-0027G	Strategic Reimb Group CY 2017 Understatement of PPS Standardized Amount Group
21-0495G	Strategic Reimb Group CY 2012-2013 Understatement of PPS Standardized Amount Group
21-0956GC	Northwestern Medicine FFY 2021 Understatement of PPS Standardized Amt. CIRP Group
21-0988GC	Hospital Sisters Health FFY 2021 Understatement of PPS Standardized Amt. CIRP Group
21-1182G	Strategic Reimb Group CY 2015 Understatement of PPS Standardized Amount Group
21-1213G	Strategic Reimb Group CY 2018 Understatement of PPS Standardized Amount Group
21-1567GC	Sinai Health CYs 2017- 2018 Understated PPS Standardized Amount CIRP Group
21-1681G	Strategic Reimb Group FFY 2021 Understatement of PPS Standardized Amount Group
21-1682GC	Sinai Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group
22-0054GC	Northwestern Medicine CY 2018 Understatement of PPS Standardized Amount CIRP Group
22-0079G	Strategic Reimb Group CY 2016 Understatement of PPS Standardized Amount Group
22-0586GC	Hospital Sisters Health FFY 2022 Understatement of PPS Standardized Amt. CIRP Group
22-0608GC	Sinai Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
22-0610GC	Northwestern Medicine FFY 2022 Understatement of PPS Standardized Amt. CIRP Group
22-0617G	Strategic Reimb Group FFY 2022 Understatement of PPS Standardized Amount Group
22-1080G	Strategic Reimb Group CY 2019 Understatement of PPS Standardized Amount Group
22-1135GC	Northwestern Medicine CY 2019 Understatement of PPS Standardized Amount CIRP Group
22-1185G	Strategic Reimb Group CY 2017 Understatement of PPS Standardized Amount Group
23-0348GC	Northwestern Medicine CY 2017 Understatement of PPS Standardized Amount CIRP Group
23-0554GC	Northwestern Medicine FFY 2023 Understatement of PPS Standardized Amt. CIRP Group
23-0573G	Strategic Reimb Group FFY 2023 Understatement of PPS Standardized Amount Group
23-0593GC	Sinai Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-0740GC	Hospital Sisters Health FFY 2023 Understatement of PPS Standardized Amt. CIRP Group
23-0708G	Strategic Reimb Group CY 2018 Understatement of PPS Standardized Amount Group
23-0739GC	Carle Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-1477G	Strategic Reimb Group CY 2020 Understatement of PPS Standardized Amount Group

On September 14, 2023, the Medicare Contractor filed a challenge to the following six (6) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-2336GC	Eastern Maine Health Syst FFY 2019 DRG Understatement CIRP Group
20-1243GC	Eastern Maine Health CYs 2014 – 2016 DRG Understatement CIRP Group
20-2102GC	Eastern Maine Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-1031GC	Northern Light Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group

22-0607GC Northern Light Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
23-0586GC Northern Light Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group

On October 16, 2023, the Medicare Contractor filed a challenge to the following six (6) cases[59] which all share a common lead Medicare Contractor, CGS Administrators (J-15):

19-2325GC Kettering Health Network FFY 2019 DRG Understatement CIRP Group
20-2036GC Kettering Health Network CY 2017 Understatement of PPS Standardized Amt. CIRP Group
20-2108GC Kettering Health Network FFY 2020 Understatement of PPS Standardized Amt. CIRP Grp.
21-0958GC Kettering Health Network FFY 2021 Understatement of PPS Standardized Amt. CIRP Grp.
22-0588GC Kettering Health Network FFY 2022 Understatement of PPS Standardized Amt. CIRP Grp.
23-0654GC Kettering Health Network FFY 2023 Understatement of PPS Standardized Amt. CIRP Grp.

On November 8, 2023, the Medicare Contractor filed a challenge to the following ten (10) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

19-0295GC Renown Health CY 2014-2015 DRG Understatement CIRP Group
19-2327GC Renown Health FFY 2019 DRG Understatement CIRP Group
19-2401GC Renown Health CY 2016 DRG Understatment CIRP Group
20-2112GC Renown Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-0021GC Renown Health CY 2017 Understatement of PPS Standardized Amount CIRP Group
21-1004GC Renown Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group
22-0643GC Renown Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
23-0740GC Renown Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-0907GC Adventist Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-1073GC Adventist Health CY 2018 Understatement of PPS Standardized Amount CIRP Group

On December 4, 2023, the Medicare Contractor filed a challenge to the following ten (10) cases which all share a common lead Medicare Contractor, Strategic Reimbursement Group, LLC (J-H):

19-2321GC CHRISTUS Health FFY 2019 DRG Understatement CIRP Group
20-0216GC CHRISTUS Health CYs 2011 & 2016 DRG Understatement CIRP Group
20-2058GC CHRISTUS Health CY 2017 Understatement of PPS Standardized Amount CIRP Group
20-2100GC CHRISTUS Health FFY 2020 Understatement of PPS Standardized Amount CIRP Group
21-1041GC CHRISTUS Health FFY 2021 Understatement of PPS Standardized Amount CIRP Group
22-0084GC CHRISTUS Health CY 2018 Understatement of PPS Standardized Amount CIRP Group
22-0584GC CHRISTUS Health FFY 2022 Understatement of PPS Standardized Amount CIRP Group
23-0568GC CHRISTUS Health FFY 2023 Understatement of PPS Standardized Amount CIRP Group
23-0569GC Presbyterian Healthcare FFY 2023 Understatement of PPS Standardized Amount CIRP Grp.
23-1661GC Presbyterian Healthcare CY 2017 Understatement of PPS Standardized Amount CIRP Grp.

[59] PRRB Case Nos. 19-2450GC & 19-2451GC were originally included in this Jurisdictional Challenge. However, they were dismissed by the Board on January 11, 2024.

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[60] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[61]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[60] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[61] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[62]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[63] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[64]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[65]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

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[62] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[63] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 18.

[64] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[65] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[66] and 1997[67] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[68]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[69] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[70] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

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[66] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[67] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[68] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[69] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[70] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[71]

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(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

[71] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

> (4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:
>
> | | *Percent* |
> |---|---|
> | Case mix..... ..... | –6.3 |
> | Market basket..... | –1.2 |
> | Composite correction factor..... | –7.5[72] |

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[73] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[74]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[75] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[76] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

---

[72] *Id.* at 35703-04 (bold and underline emphasis added).
[73] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[74] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[75] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[76] 51 Fed. Reg. at 16773.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[77]

[77] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[78]

[78] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Notice of Dismissal – Updated Rationale***
Katten Muchin Standardized Amount CIRP Group Cases
Case Nos. 19-1643GC, *et al.* (*see* **Appendix A** listing 5 group cases)

Dear Mr. Willey:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five (5) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all five (5) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably tied* with those

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress'

applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs wand because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Katten Muchin Rosenman, LLP ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering five (5) group cases.[7] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all five (5) cases are materially identical and can be considered together.

The issue presented is:

> This case relates to Medicare reimbursement due the Hospitals, as determined by the Secretary under the IPPS pursuant to 42 U.S.C. §§ 1395ww(d), *et seq*., and specifically to the Secretary's decision to treat patient transfers as discharges in determining the "average standardized amounts for fiscal year ("FY") 1984, from which IPPS rates have derived

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decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 52 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

> ever since. This has resulted in an understatement of the federal DRG prospective payment amounts paid to the Hospitals for FY 1984 and following, and, in particular, for the fiscal year at issue.[8]

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position paper, they explain that the IPPS requires the categorization of different types of discharges (diagnostic related groups, or "DRGs"), and payment rates applicable to each discharge category. Their appeals challenge the latter, arguing that the data used to establish the initial rate payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[9]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[11] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885(a)(1)(iii) and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates both the Medicare Act and Administrative Procedure Act. Finally, they argue that the understated Standardized Amounts and their resulting understated Medicare payments produces cost shifting prohibited by 42 U.S.C. § 1395x(v)(1)(A)(i).[12]

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[8] *E.g.,* Case 19-1643GC, Providers' Preliminary Position Paper at 2 (Apr. 14, 2022).
[9] *Id.* at 7.
[10] *Id.* at 15 (citing 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991) (related to capital PPS). *See also* Ex. P-8.
[11] *Id*. at 8, footnote 9. ("Because this appeal concerns the unlawful application in FY 2016 of a prospective payment rate reflective of the understated average standardized amounts that were calculated for FY 1984 per the IPPS Statute, the subsequent, redesignated regulations published on March 29, 1985 at Part 412 in 50 Fed. Reg. 12740, and any amendments thereto did not govern the FY 1984 rate-setting.").
[12] *Id*. at 17.

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge covering five (5) different group cases, and the Providers filed a response in each case.[13] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges reiterated that the group appeal does "***not*** seek to correct any of the 1981 cost report data underlying the original calculation of the FFY 1984 standardized amounts; they are seeking correction of an error in the ***methodology the Secretary applied to that very same 1981 data*** to compute those FFY1984 standardized amounts. . ."[14] They claim that the budget-neutral adjustments and any preclusion provisions do not apply to their IPPS challenges. The ask the Board to find it has jurisdiction over these appeals.

The Providers counter the Medicare Contractor by arguing that budget neutrality adjustments are not applicable to these appeals. They further claim that neither 42 U.S.C. §§ 1395ww(d)(7)(A) nor 1395oo(g)(2) restrict challenges to the methodology deriving from the original Standardized Amount based on the 1981 data.[15] They argue that there is a strong presumption in favor of judicial review, and that in this instance there is not clear indication that Congress intended to preclude review of more recent FFY Standardized Amounts or the predicate facts related to the methodology for calculating the 1983 Standardized Amount.[16]

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 5 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[17] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[18]; (2) the FFY 1985 budget neutrality-adjusted rates were used to

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[13] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.
[14] *E.g.*, PRRB Case 19-1643GC *et al.*, Providers' Response to MAC's Jurisdictional Challenges at 19 (Nov. 13, 2023) (bold and italics emphasis included).
[15] *Id.* at 18.
[16] *Id.*
[17] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[18] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).

determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[19] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[20] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[21]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[22] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[23] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[24] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed

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[19] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[20] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[21] *Id.*
[22] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[23] *Id.* (emphasis added).
[24] *Id*. at 39763-64.

the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[25] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[26]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

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[25] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[26] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[27]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[28]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average

[27] (Italics emphasis in original and bold and underline emphasis added.)
[28] (Italics emphasis in original and bold and underline emphasis added.)

payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[29] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1⁄2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points

[29] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[30]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the

[30] (Emphasis added.)

> Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget

neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.* (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.
> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage

> change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[31]

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS

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[31] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[32]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e*., adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[33] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[34]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[35]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[36] More specifically, the amalgamated

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[32] *See e.g.,* PRRB Case No. 19-1643GC, Providers' Response to MAC's Jurisdictional Challenge at 4 ("It is exactly those "***initial*** FFY 1984 standardized amounts" calculated at ***42 U.S.C. §§ 1395ww(d)(2)(D) and (3)(A)*** *– i.e., before* the budget neutrality adjustments are made – that flow forward from year to year, ultimately into the years under appeal herein."

[33] *See* **Appendix B.**

[34] *See supra* note 17 accompanying text.

[35] *See id.*

[36] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[37]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[38]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

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[37] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[38] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[39]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from FFY 1985 forward for use in the IPPS system *for purposes of future FFYs*.[40]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

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[39] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[40] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98--21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.

> • *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
>
> • *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[41]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[42] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[43]

Accordingly, while the Providers did not appeal the budget neutrality adjustments, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of

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[41] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[42] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[43] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[44]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".

[44] *Id.* at 255.

> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[45]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[46]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget***

[45] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[46] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> ***neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[47]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[48] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[49]

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[47] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[49] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather they challenge "the understatement of those ***initial*** pre-budget neutrality standardized amounts that has caused the undeniable harm to the Hospitals with respect to their IPPS reimbursement for each of the Fiscal Years [under appeal]."[50] They also claim that the Budget Neutrality Preclusion Provisions are not applicable here because they only bar administrative and judicial review of *a **narrow** category of challenges* to the Secretary's determination of the requirement, or the proportional amount, of any budget neutrality adjustment effected pursuant to 42 U.S.C. § 1395ww(e)(1) in FFYs 1984 and 1985.[51]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[52] Therefore, the *final* FFY 1984 and 1985 standardized amounts are

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[50] *See e.g.,* Case No. 19-1643GC *et al.*, Providers' Response to MAC Jurisdictional Challenge at 4.
[51] *See e.g., id*. at 13-14.
[52] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably tied, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably tied with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the

inextricably intertwined with those applicable budget neutrality adjustments.[53] Indeed, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts

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"data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrates that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[53] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the

by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[54] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amounts for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[55]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the five (5) CIRP group cases listed in **Appendix A**, and hereby closes these five (5) group cases and removes them 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:

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For the Board:

3/4/2024

X Clayton J. Nix

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

Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[54] *See supra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[55] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS
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APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 14, 2023, the Medicare Contractor filed a challenge to the following five (5) cases which all share a common lead Medicare Contractor, National Government Services, Inc. (J-K):

19-1643GC	NYCHHC CY 2016 Base Yr Determination of the IPPS Standardized Rate CIRP Group
21-1508GC	NYCHHC CY 2017 Base Year Determination of the IPPS Standardized Rate CIRP Group
22-0313GC	NYCHHC CY 2019 Base Year Determination of the IPPS Standardized Rate CIRP Group
22-0800GC	NYCHHC CY 2018 Base Year Determination of the IPPS Standardized Rate CIRP Group
23-1276GC	NYCHHC CY 2020 Base Year Determination of the IPPS Standardized Rate CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[56] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[57]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[56] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[57] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[58]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[59] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[60]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[61]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

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[58] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[59] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 17.

[60] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[61] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[62] and 1997[63] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[64]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[65] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[66] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

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[62] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[63] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[64] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[65] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[66] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes

is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[67]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later

[67] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

(1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

(4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	Percent
Case mix.....	–6.3
Market basket.....	–1.2
Composite correction factor.....	–7.5[68]

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[69] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[70]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[71] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[72] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985

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[68] *Id.* at 35703-04 (bold and underline emphasis added).
[69] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[70] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[71] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[72] 51 Fed. Reg. at 16773.

standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as **now** proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[73]

[73] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[74]

[74] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Charles Jeffress
Brazosport Regional Health System
100 Medical Dr.
Lake Jackson, TX 77566

RE: ***Notice of Dismissal***
Brazosport Regional Health System (Provider Number 45-0072)
FFY 2021
Case Number: 21-0649

Dear Mr. Jeffress:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Brazosport Regional Health System's Individual Appeal Request in Case No. 21-0649 on January 29, 2021. The sole issue in the appeal is the Quality Reporting Payment Reduction.

The Provider failed to appear at its March 5, 2024 hearing for this case.

The Board may dismiss an appeal due to a Provider's failure to appear for a scheduled hearing pursuant to Board Rule 30.2 (Nov. 1, 2021), which states that "[e]xcept for good cause beyond a provider's control, the Board will dismiss a case if the provider fails to appear at the hearing." Further, Board Rule 41.2 provides that the Board may dismiss a case on its own motion upon failure of the provider to comply with Board procedures, citing 42 C.F.R. § 405.1868, and upon failure to appear for a scheduled hearing. The regulation at 42 C.F.R. § 405.1868 provides, in pertinent part:

> (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.

The Provider failed to appear at the hearing. Accordingly, the Board hereby dismisses Case No. 21-0649 with prejudice and removes it from the Board's docket.

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

Board Members:

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

For the Board:

3/5/2024

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
Joseph Bauers, Esq. Federal Specialized Services
Michael Redmond, Novitas Solutions, Inc (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Lakeway Regional Hospital (Provider Number: 44-0067)
FYE: 05/31/2017
Case Number: 20-1279

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 20-1279 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

Procedural History for Case No. 20-1279

On September 11, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end May 31, 2017.

On February 7, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage[1]
3. DSH – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to CHS groups on September 22, 2020.

[1] On September 22, 2020, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On March 2, 2023, the Provider withdrew this issue.
[3] On July 12, 2023, the Provider withdrew this issue.
[4] On September 22, 2020, this issue was transferred to PRRB Case No. 20-0999GC.

With the withdrawal of Issues 3 and 4, the DSH – SSI Percentage (Provider Specific), issue is the sole remaining issue pending in the appeal.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[5]

On September 30, 2020, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (May 31).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR

[5] Issue Statement at 1 (Feb. 7, 2020).

> data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[6]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

The MAC argues that the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered to be the same issue by the Board and should be dismissed. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[7] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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.

A. DSH – SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine

[6] Provider's Preliminary Position Paper at 8-9.
[7] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[8] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[9] The Provider argues that it "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."[10]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board hereby dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board 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, the Provider has failed to explain how this argument is ***specific to this provider***, as the issue statement asserts. 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.[11] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

---

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

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

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[12]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[13]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra,* No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 20-1279 and the group issue from Group Case 20-0997GC are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed as premature. 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…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment and, as such, there is no "determination" to appeal and the appeal of this issue is therefore premature.

****

In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers. As this is the last remaining issue, the appeal is now closed.

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

[12] Last accessed March 4, 2024.
[13] Emphasis added.

Board Members Participating:

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

For the Board:

3/6/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Andrew Dreyfus
HealthQuest Consulting, Inc.
161 Fashion Lane, Suite 202
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RE: ***Notice of Dismissal – Updated Rationale***
HealthQuest Standardized Amount CIRP Group Cases
Case Nos. 18-1860GC, *et al.* (*see* **Appendix A** listing 5 group cases)

Dear Mr. Dreyfus:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the five (5) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. The Providers' Representative filed responses to these challenges. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all five (5) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress'

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

HealthQuest Consulting, Inc. ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") and optional groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering five (5) group cases.[7] The Providers' Representative filed responses to these challenges. The group issue statements, jurisdictional challenges, and responses thereto for all five (5) cases are materially identical and can be considered together.

The issue presented is:

> Whether the Hospital has been underpaid for the FYE 12/31/14 because the inpatient hospital prospective payment (PPS) standardized amounts are understated for the FFY 14 & FFY 15 due to the Secretary's failure to

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decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[3] *See infra* note 51 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).

[4] *See infra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.

[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.

[7] *See* **Appendix A**.

> properly distinguish between patient transfers and discharges in establishing the PPS 1983 base year amounts.[8]

Procedural Background:

A. Appealed Issue

In the Providers' preliminary position paper, they explain that under the IPPS, hospitals are paid a fixed amount for each Medicare beneficiary that they treat. The fixed amount is calculated each year starting with a base rate. Their appeals challenge that base rate, arguing that the data used to establish the initial rate payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[9]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register.[11] They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885 and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates the Medicare Act.

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge covering five (5) different group cases, and the Providers filed a response in each case.[12] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter

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[8] *E.g.,* Case 18-1860GC, Group Issue Statement at 1 (Sept. 10, 2018).
[9] *See e.g.*, PRRB Case No. 19-2114GC, Providers' Preliminary Position Paper at 2 (Feb. 16, 2022).
[10] *Id.* at 4 (citing 56 Fed. Reg. 43358, 43386 (Aug. 30, 1991) (related to capital PPS).
[11] *See e.g.,* Case 18-1860GC, Group Issue Statement at 1-2.
[12] *See* **Appendix A** for a complete list of challenges and cases impacted. As previously noted, the challenges are all materially identical.

jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing five (5) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Providers' responses to these challenges requested that the Board "not issue a ruling on jurisdiction at this time and that it suspend all due dates in the subject cases until *St. Mary's Hospital v. Becerra*, No. 23-cv-1594 (RCL) (D.D.C.) is finally decided."[13] The Providers argue that in the *St. Mary's* case, the appeal is from April 6, 2023 PRRB Dismissal and the Secretary did not file a motion to dismiss based on a lack of jurisdiction but answered the complaint. They go on:

> Therefore, it appears, at least at this time, that the Secretary would not defend a dismissal of jurisdiction by the PRRB in the subject cases, similar to the Secretary's decision not to defend the PRRB's denial of jurisdiction in the *Cape Cod Hospital* rural floor budget neutrality litigation (which involved the same statutory preclusion statute, section 1886(d)(7) of the Social Security Act).[14]

Additionally, the Providers argue they would be disadvantaged by a Board dismissal at this time as it would:

> force the providers to go through the time and expense of filing complaints at this time, in order to challenge a Board dismissal of jurisdiction, and have to pick the district in which they wish to file. If they pick the District of Columbia and *St. Mary's Hospital* is finally determined in the providers' favor, they will get the benefit of that determination, but if *St. Mary's Hospital* is finally decided in the Secretary's favor they will be disadvantaged by having to choose up front which district in which to file.[15]

The Providers go on to argue that the dual venue provision of the Social Security Act was purposefully created to allow providers to receive the benefit of a favorable DC Circuit decision "while allow them to file elsewhere if DC Circuit law is unfavorable on a particular issue."[16]

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[13] *E.g.*, PRRB Case No. 18-1860GC, Providers' Response to MACs' Jurisdictional Objections at 1 (Nov. 1, 2023).
[14] *Id*. at 1-2.
[15] *Id*. at 2.
[16] *Id*.

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the 5 groups because: (1) the initial IPPS standardized amounts set for FFY 1984[17] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[18]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[19] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[20] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[21]

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[22] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[23] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital

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[17] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[18] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[19] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[20] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[21] *Id.*
[22] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[23] *Id.* (emphasis added).

> services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[24] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[25] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .
>
> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—

[24] *Id*. at 39763-64.
[25] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[26]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[27]

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient

[26] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[27] (Italics emphasis in original and bold and underline emphasis added.)

> operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[28]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than* ***or*** *less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e*., reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more* ***and*** *no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[29] Since these points are ***fixed,*** it also means that it is capped (*i.e*., cannot be increased subsequently outside of the budget neutrality adjustment).

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

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[28] (Italics emphasis in original and bold and underline emphasis added.)

[29] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) ***for fiscal year 1986***, 1/2 percent,

(II) for fiscal year ***1987***, 1.15 percent,

(III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,

(IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,

(V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,

(VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,

(VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located

> in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),
>
> (XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,
>
> (XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,
>
> (XIII) for fiscal year ***1998***, 0 percent,
>
> (XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,
>
> (XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,
>
> (XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,
>
> (XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,
>
> (XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and
>
> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[30]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the***

[30] (Emphasis added.)

fiscal year involved by the applicable percentage increase under subsection (b)(3)(B). With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).

(ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.

(iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.

(II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous

> fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—
>
> (A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
> (D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

> (ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective <u>adjusted</u> average standardized amounts <u>computed for the previous fiscal year</u>**—
>
> (A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and
>
> (B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.
>
> (C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.
>
> (3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[31]

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[31] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY thereafter*** *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[32]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[33] Thus, the standardized

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> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

[32] *See e.g.,* Case 18-1860GC, Group Issue Statement at 1 ("The error in the original standardized amount calculation has been perpetuated because the standardized amount has been updated annually for inflation but not recalculated each year.")

[33] *See* **Appendix B.**

amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[34]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[35]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e*., no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[36] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[37]

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[34] *See supra* note 17 accompanying text.
[35] *See id.*
[36] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").
[37] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[38]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—
>
> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[39]

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c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.

We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[38] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

[39] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost.
> It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e*., no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[40]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

> Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."
>
> Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of**

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concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[40] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

> **certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.
>
> **The adjustment of the Federal portion was determined as follows**:
>
> - *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
> - *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
> - *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
> - *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
> - *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.
>
> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[41]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[42] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

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[41] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[42] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[43]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[44]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too

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[43] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

[44] *Id.* at 255.

high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e*., no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e*., as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.
>
> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[45]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the

[45] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[46]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986 standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[47]

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[46] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

[47] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[48] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[49]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[49] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather "seeks a correction to the standardized amount calculation in the base year (1983) that would allow for correction of the Secretary's error in each every [sic] subsequent year and correction recalculation of the PPS payment in the current appealed year."[50]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base that was set *using 1981 data*.[51] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[52] Indeed, the Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in

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[50] Case 18-1860GC, Group Issue Statement at 1-2.

[51] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

[52] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

setting the initial base rate (which again was based on *1981 data*).[53] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amount for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[54]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the five (5) CIRP group cases listed in **Appendix A**, and hereby closes these five (5) group cases and removes them 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:

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For the Board:

3/6/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

[53] *See supra* note 37 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[54] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

APPENDIX A
Jurisdictional Challenges and Responses; Cases at Issue

On September 22, 2023, the Medicare Contractor filed a challenge to the following five (5) cases which all share a common lead Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

18-1860GC	Avanti Hospitals CY 2014 Understated Standardized Amount CIRP Group
19-2114GC	Avanti CY 2015 Understated IPPS Standardized Amount CIRP Group
20-1959GC	Avanti CY 2016 Avanti CY 2016 Understated IPPS Standardized Amount CIRP Group
22-0110GC	Avanti CY 2017 Understated Standardized Payment Amount CIRP Group
23-1144GC	Avanti CY 2018 Standardized Amount Base Rate Accuracy CIRP Group

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[55] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[56]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[55] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[56] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[57]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[58] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[59]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[60]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

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[57] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[58] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 17.

[59] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[60] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[61] and 1997[62] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[63]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[64] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[65] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

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[61] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[62] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[63] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[64] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[65] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes

> is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:
>
> | | Percent |
> |---|---|
> | Forecasted market basket increase.. | +4.27 |
> | Part B costs and FICA taxes..... | +.31 |
> | Composite correction factor..... | –7.5 |
> | Composite policy target adjustment factor..... | –1.5 |
>
> However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[66]
>
> ****
>
> (3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.
>
> When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.
>
> **For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates.** The hospital specific rates were set using later (1982

[66] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit recoveries, it is likely that they are overstated by a similar amount**. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

(4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	Percent
Case mix.....	–6.3
Market basket.....	–1.2
Composite correction factor.....	–7.5[67]

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[68] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[69]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[70] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[71] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985

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[67] *Id.* at 35703-04 (bold and underline emphasis added).
[68] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[69] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[70] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[71] 51 Fed. Reg. at 16773.

standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as* ***now*** *proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[72]

[72] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.
> For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment**

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**
>
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals

---

methodology. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[73]

[73] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nathaniel K. Summar
Community Health Systems, Inc.
4000 Meridian Blvd.
Franklin, TN 37067

RE: ***Board Decision***
Weatherford Regional Medical Center (Provider Number 45-0203)
FYE: 10/31/2016
Case Number: 21-0089

Dear Mr. Summar,

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the Medicare Contractor's Jurisdiction Challenge and Motion to Dismiss filed in the above referenced case. The Board's analysis and determination is set forth below.

Background:

A. Procedural History for Case No. 21-0089

Weatherford Regional Medical Center submitted a request for hearing on May 18, 2020, from a Notice of Program Reimbursement ("NPR") dated November 25, 2019. The hearing request included the following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage- Provider Specific
- Issue 2: Disproportionate Share Hospital (DSH) Payment Supplemental Security Income (SSI) Percentage[1]
- Issue 3: DSH- Medicaid Eligible Days
- Issue 4: 2 Midnight Census IPPS Payment Reduction[2]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a CHS group on January 26, 2021.

On May 3, 2021, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. The Provider did not file a response to the MAC's Jurisdictional Challenge.

[1] Transferred to PRRB Appeal 19-1409GC on January 26, 2021.
[2] Withdrawn on February 8, 2021.

On August 8, 2023, the Medicare Contractor filed a Motion to Dismiss Issue 3- DSH Medicaid Eligible Days. The Provider's representative, Community Health Systems ("CHS"), has not filed any response to the Medicare Contractor Motion to Dismiss which, per Board Rule 44.3 was due within 30 days.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

The Provider's appeal request describes Issue 1 – DSH SSI Percentage (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 how 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' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS is flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[3]

The Provider was also transferred into a mandatory group under Case No. 19-1409GC entitled "*CHS CY 2016 DSH SSI Percentage CIRP Group*." This CIRP group has the following issue statement:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the number of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[3] Provider's Request for Hearing, Issue Statement (May 18, 2020)

Statement of the Legal Basis:

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH payments are not in accordance with the Medicare statute 42 U.S.C. §1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) that the SSI percentages calculated by the Centers for Medicare and Medicaid Services ("CMS") and used by the MAC to settle their Cost Report incorporates a new methodology inconsistent with the Medicare statute.

The Providers challenge their SSI percentages based on the following reasons:

1. Availability of MEDPAR and SSA Records;
2. Paid days vs. Eligible days;
3. Not in agreement with provider's records;
4. Fundamental problems in the SSI percentage calculation;
5. Covered days vs. Total days; and
6. Failure to adhere to required notice and comment rulemaking procedures.[4]

On February 8, 2021, the Provider filed its preliminary position paper. The following is the Provider's complete position on Issue 1 set forth therein:

Calculation of the SSI Percentage

Provider Specific

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

The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.

Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94- 0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review

[4] See Group Issue Statement, PRRB Case No. 19-1409GC

> ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000. Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

Medicare Contractor's Contentions

Issue 1 – DSH SSI Percentage (Provider Specific)

On May 3, 2021, the Medicare Contractor filed a Jurisdictional Challenge over Issue 1. The MAC contends that the portion of Issue 1 concerning SSI data accuracy should be dismissed because it is "duplicative of the issue under appeal in Group Case No. 19-1409GC,"[5] The Provider transferred the individual Issue 2 to the *"CHS CY 2016 DSH SSI Percentage CIRP Group.*" The Portion of Issue 1 concerning realignment should be dismissed "because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies."[6]

Issue 3 – DSH Medicaid Eligible Days

On August 8, 2023, the Medicare Contractor filed a Motion to Dismiss the Medicaid Eligible Days issue arguing that the Provider has effectively abandoned the issue by failing to furnish documentation in support of its claim for additional Medicaid Eligible Days or describe why such documentation was and continues to be unavailable.[7] The Motion outlines the Board's Rules which require a Provider to submit supporting documentation with its appeal or otherwise explain why it is unavailable, and what steps are being taken to obtain it. The Medicare Contractor also points to 42 C.F.R. § 412.106(b)(4)(iii) and § 413.24(c), which places the burden on the Provider with regard to furnishing this documentation.[8] Finally, the Motion notes that the Provider's Preliminary Paper stated that an eligibility listing was being sent under separate cover. The Medicare Contractor claims that no listing has ever been provided in the 3 years since the appeal was filed. The MAC requests the Board to dismiss the additional Medicaid Eligible Days issue because the Provider has failed to furnish documentation in support of its claim.[9]

Provider's Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare

[5] MAC's Jurisdictional Challenge, at 2.
[6] *Id.*
[7] MAC's Motion to Dismiss at 5.
[8] *Id.* at 4.
[9] *Id.* at 1-2.
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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.

A. SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

1. First Aspect of Issue 1

The Board finds that the first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred into Group Case No. 19-1409GC, *CHS CY 2016 DSH SSI Percentage CIRP Group*.

The first aspect of Issue 1 in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[11] 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)."[12] 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."[13] The DSH SSI issue transferred into Case No. 19-1409GC 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).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of the group issue in Case No. 19-1409GC, for this same provider and fiscal year. Because the issue is duplicative, and

[11] Individual Appeal Request, Issue 1.
[12] *Id.*
[13] *Id.*

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 pursuing that issue as part of the group under Case No. 19-1409GC. 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.[14] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) in its appeal request of 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. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

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

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [15]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[16]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board must find that Issue 1 and the group issue in Group 19-1409GC 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. As an alternative basis the Board dismisses Issue 1 for failure of the Provider to properly brief the issue in its position paper in compliance with Board Rules.

2. Second Aspect of Issue 1

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed for lack of jurisdiction and as premature. 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

[15] Last accessed March 4, 2024.
[16] Emphasis added.

data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment as such there is no "determination" to appeal and the appeal of this issue is otherwise premature.

B. DSH- Medicaid Eligible Days

According to its Appeal Request filed on May 18, 2020, the Provider asserts that all Medicaid eligible days were not included in the calculations of the DSH calculations for FY 2016. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[17]

The Provider's appeal request did not include a list of the specific additional Medicaid eligible days that are in dispute in this appeal and which the Provider desired to be included in their Medicaid percentage and DSH computations.

With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) (Dec. 2013) states:

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

[17] Provider's Appeal Request (May 18, 2020).

However, when Community Health Systems ("CHS") filed the May 18, 2020 appeal request, CHS did not indicate that there were issues with accessing information underlying the adjustment to its Medicaid eligible days.

42 C.F.R. § 405.1853(b)(2)-(3) addresses the content of position papers:

> (b) *Position papers*. . . . (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.**
>
> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. **Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board** through a schedule applicable to a specific case or through general instructions.[18]

Essentially, the regulations require the parties to fully brief the merits of each issue in their position paper (including the relevant facts and legal arguments) and further specify that the Board has discretion about setting the time frame for the submission of exhibits supporting the merits of the appeal.

The Board Rule 27.2 (2018) specifies that "[t]he final position paper should address each remaining issue" and that "[t]he ***minimum*** requirements for the position paper narrative and exhibits are the ***same*** as those outlined for preliminary position papers at Rule 25."[19] Board Rule 25 (2018) gives the following instruction on the content of position papers:

> Rule 25 Preliminary Position Papers
>
> **COMMENTARY:**
>
> Under the PRRB regulations effective August 21, 2008, all issues will have been identified within 60 days of the end of the appeal filing period. The Board will set deadlines for the first position paper generally at eight months after filing the appeal request for the provider, twelve months for the Medicare contractor, and fifteen months for the provider's response. *Therefore, preliminary position papers are expected to present fully developed positions of the parties and, therefore, require analysis well in advance of the filing deadline.*

[18] (Bold emphasis added.)
[19] (Bold emphasis added.)

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the following sub-sections.

25.1.1 Provider's Position Paper

A. Identify any issues that were raised in the appeal but are already resolved (whether by administrative resolution, agreement to reopen, transfer, withdrawal, dismissal, etc.) and require no further documentation to be submitted.

B. For each issue that has not been fully resolved, state the material facts that support the provider's claim.

C. Identify the controlling authority (e.g., statutes, regulations, policy, or case law) supporting the provider's position.

D. Provide a conclusion applying the material facts to the controlling authorities.

****

25.2 Position Paper Exhibits

24.2.1 General

With the position papers, the parties must exchange all available documentation as exhibits to fully support your position. The Medicare contractor must also give the provider all evidence the Medicare contractor considered in making the determination (see 42 C.F.R. § 405.1853(a)(3)) and identify any documentary evidence that the Medicare contractor believes is necessary for resolution but has not been submitted by the provider. When filing those exhibits in the preliminary position paper, ensure that the documents are redacted in accordance with Rule 1.4. Unredacted versions should be exchanged by the parties separately from the position paper, if necessary.

25.2.2 Unavailable and Omitted Documents

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

> available, promptly forward them to the Board and the opposing party.
>
> **25.2.3 List of Exhibits**
>
> Parties must attach a list of the exhibits exchanged with the position paper.
>
> **25.3 Filing Requirements to Board**
>
> Parties should file with the Board a complete preliminary position paper with a fully developed narrative (Rule 23.1), all exhibits (Rule 23.2), a listing of exhibits, and a statement indicating how a good faith effort to confer was made in accordance with 42 C.F.R. § 405.1853. Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

Consistent with Board Rule 25 and § 405.1853(b)(2)-(3), the Commentary to Board Rule 23.3 discussing the filing of proposed joint scheduling orders versus preliminary position papers includes the following commentary on position paper requirements:

> **COMMENTARY:**
>
> The regulations and Board Rules impose preliminary position paper requirements that ensure ***full development*** *of the parties' positions in order to foster efficient use of the administrative review process*. The due date timeframe is set to give the parties the optimal opportunity to develop their case. Because the date for adding issues will have expired and transfers are to be made prior to filing the preliminary position papers, *the Board requires preliminary position papers to be* ***fully developed*** *and include* ***all available documentation*** *necessary to provide a* ***thorough understanding*** *of the parties' positions*.
>
> CAUTION: New arguments and documents not included in the preliminary position paper may be excluded at the hearing unless the parties demonstrate good cause (e.g., subsequent case law or documents were unavailable through no fault of the party offering the evidence).

Moreover, Medicare regulations specifically place the burden on hospitals to provide documentation from the State to establish each Medicaid eligible day being claimed. Specifically, when determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

- if it has a reasonable basis to believe that the issues have been fully settled or abandoned
- upon failure of the provider or group to comply with Board procedures,
- if the Board is unable to contact the provider or representative at the last known address, or
- upon failure to appear for a scheduled hearing.

On February 8, 2021, the Provider filed their preliminary position paper in which it indicated that it would be sending the eligibility listing under separate cover.[20] The position paper did not identify how many Medicaid eligible days remained in dispute in this case. Specifically, the Provider's complete briefing of this issue in its position paper is as follows:

> **Calculation of Medicaid Eligible Days**
>
> Specifically, the Provider disagrees with the MAC's determination of the computation of the disproportionate patient percentage set forth at 42 C.F.R. § 412.106(b)(4) of the Secretary's Regulations.
>
> The Sixth Circuit Court of Appeals, in *Jewish Hosp. Inc. v. Secretary of Health and Human Servs.*, 19 F.3d 270 (6th Cir. 1994), held that all patient days for which the patient was eligible for Medicaid, regardless of whether or not those days were paid by the state, should be included in the numerator of the Medicaid percentage when the DSH adjustment is calculated. Similar decisions were rendered by the Fourth, Eighth and Ninth Circuits: *Cabell Huntington Hospital, Inc. v. Shalala*, 101 F.3d 984 (4th Cir. 1996); *Deaconess Health Services Corp. v. Shalala*, 83 F.3d 1041 (8th Cir. 1996), *aff'g* 912 F. Supp. 478 (E.D. Mo. 1995); and *Legacy Emanuel Hospital and Health Center v. Shalala*, 97 F.3d 1261 (9th Cir. 1996).

[20] Provider's Preliminary Position Paper at 8 (February 8, 2021).

> The Centers for Medicare and Medicaid Services ("CMS", formerly HCFA) acquiesced in the above decisions and issued HCFA Ruling 97-2, which in pertinent part reads as follows:
>
> > [T]he Medicare disproportionate share adjustment under the hospital inpatient prospective payment system will be calculated to include all inpatient hospital days of service for patients who were eligible on that day for medical assistance under a state Medicaid plan in the Medicaid fraction, whether or not the hospital received payment for these inpatient hospital services.
>
> Based on the Listing of Medicaid Eligible Days being sent under separate cover, the Provider contends that the total number of days reflected in its' [*sic*] 2016 cost report does not reflect an accurate number of Medicaid eligible days, as required by HCFA Ruling 97-2 and the pertinent Federal Court decisions.

In its Motion to Dismiss, the MAC asserts that the Provider has failed to submit a list of additional Medicaid eligible days. While the Calculation Support filed with their appeal notes a net impact of $52,000, with an increase in days, it is unclear whether this amount continues to be in dispute as of the Provider's filing of the position paper. Moreover, the MAC asserts that the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover, as was implied in the Provider's Preliminary Position Paper. The MAC thus asserts that the Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[21]

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Specifically, the Board finds that the Provider has failed to satisfy the requirements of 42 C.F.R. § 412.106(b)(iii) and 405.1853(b)(2)-(3) and Board Rules 25.2.1 and 25.2.2 related to the submission of documentary evidence required to support its claims or describe why said evidence is unavailable as well as failed to fully develop the merits of the Medicaid eligible days issue because CHS has failed to identify any specific Medicaid eligible days at issue and failed to produce a listing of the specific days at issue (much less any supporting documentation for those days.)[22] Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the

[21] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.
[22] Board Rule 25, of which 25.2.1 and 25.2.2 are a part, is applicable to final position papers via Board Rule 27.2.

Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[23] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. In this regard, the Board notes that the Provider represented in its preliminary position paper filed on February 8, 2021 that "the Listing of Medicaid Eligible days [are] being sent under separate cover."[24] This was suggestive that a listing had been completed and was imminent. However, no such listing has ever been received by either the Board or the Medicare Contractor notwithstanding the Provider's representation that such a listing was available and ready, and the Medicare Contractor's request for such a listing, to which the Provider failed to provide a response.

****

In summary, the Board hereby dismisses the SSI Provider Specific Issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC, there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, and the Provider failed to meet the Board requirements for position papers.

The Board also dismisses Issue 3, DSH Medicaid Eligible Days, as the Provider has failed to meet the Board requirements for position papers for this issue relative to developing the merits of its case and failed to file supporting exhibits, as required under 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rules 27.2 and 25. The Provider has also not provided any timely explanation to the MAC as to why the documentation was absent or what is being done to obtain it, notwithstanding the age of this case.

Further, the Board takes administrative notice that it has made similar dismissals in other cases in which CHS was the designated representative and, notwithstanding, CHS failed to provide the Medicaid eligible days listing with its preliminary position paper.

As there are no more issues still pending in the appeal, the case is closed and removed from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

3/7/2024

X Kevin D. Smith, CPA

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

[23] (Emphasis added.)
[24] Provider Preliminary Position Paper at 8.

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nathaniel K. Summar
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RE: ***Board Decision***
Bluffton Regional Medical Center (Provider Number: 15-0075)
FYE: 09/30/2017
Case Number: 21-0162

Dear Mr. Summar:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case No. 21-0162 pursuant to a jurisdictional challenge filed by the Medicare Administrative Contractor ("MAC"). The Board's decision is set forth below.

Background

Procedural History for Case No. 21-0162

On February 13, 2020, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2017.

On July 28, 2020, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained four (4) issues:

1. DSH – SSI Percentage (Provider Specific)
2. DSH – SSI Percentage[1]
3. DSH – Medicaid Eligible Days[2]
4. 2 Midnight Census IPPS Payment Reduction[3]

As the Provider is commonly owned by Community Health Systems, Inc. ("CHS"), and thereby, subject to the mandatory Common Issue Related Party ("CIRP") regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to a CHS group on February 23, 2021.

[1] On February 23, 2021, this issue was transferred to PRRB Case No. 20-0997GC.
[2] On March 2, 2023, the Provider withdrew this issue.
[3] On February 17, 2021, this issue was withdrawn in the Provider's Preliminary Paper Cover Letter.

On May 25, 2021, the MAC filed a Jurisdictional Challenge over Issue 1- DSH SSI Provider Specific. The Provider did not file a response to the MAC's Jurisdictional Challenge.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-0997GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[4]

On February 25, 2021, the Provider submitted its preliminary position paper to the MAC. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Indiana and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Indiana and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination

[4] Issue Statement at 1 (July 28, 2020).

> of the SSI percentage. *See* 65 Fed. Reg. 50, 548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[5]

MAC's Contentions

Issue 1 – DSH – SSI Percentage (Provider Specific)

The MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board and should be dismissed. Additionally, the portion related to SSI realignment should be dismissed because there was no final determination over SSI realignment and the appeal is premature as the Provider has not exhausted all available remedies.

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[6] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Analysis and Recommendation

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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.

A. DSH – SSI Percentage (Provider Specific)

The analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

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[5] Provider's Preliminary Position Paper at 8-9.
[6] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

1. *First Aspect of Issue 1*

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH – SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-0997GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation."[7] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] The Provider argues that it "disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-0997GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds that the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-0997GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6, the Board hereby dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board 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, the Provider has failed to explain how this argument is ***specific to this provider***, as the issue statement asserts. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[10] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors are specific to this provider.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1 and finds that the Provider's Preliminary Position Paper failed to comply with

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

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

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> 25.2.2 Unavailable and Omitted Documents If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [11]

[11] Last accessed March 4, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[12]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra,* No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, based on the record before it, the Board finds that the SSI Provider Specific issue in Case No. 21-0162 and the group issue from Group Case 20-0997GC are the same issue, and the that the Provider failed to properly brief the issue in its position paper, in compliance with Board Rules. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH payment/SSI Percentage (Provider Specific) issue.

2. *Second Aspect of Issue 1*

The second aspect of the DSH SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—must be dismissed as premature. 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…" Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding the Provider's DSH SSI Percentage realignment and, as such, there is no "determination" to appeal and the appeal of this issue is otherwise premature. Further, the Provider's cost reporting period ends on 9/30, making it congruent with the federal fiscal year end. Thus, any realignment of the SSI percentage would have no effect on settlement.

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In summary, the Board hereby dismisses the SSI Provider Specific issue as there is no final determination from which the Provider can appeal the SSI realignment portion of the issue, the issue is duplicative of the group issue in Group Case No. 20-0997GC, and the Provider failed to meet the Board requirements for position papers. The appeal is closed as no issues remain.

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

[12] Emphasis added.

Board Members Participating:

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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

3/7/2024

X Kevin D. Smith, CPA

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

cc: Wilson Leong, Federal Specialized Services
Byron Lamprecht, WPS Government Health Administrators (J-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
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RE: ***Notice of Dismissal***
Case No. 24-0416GC, *et al.* (*see* **Appendix A** listing 13 cases)

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the thirteen (13) above-referenced common issue related party ("CIRP") group and individual cases. Set forth below is the decision of the Board to dismiss these 13 appeals challenging the Treatment of Part C Days from the Final Rule.

Background

Quality Reimbursement Services, Inc. ("QRS") represents a number of Providers in CIRP groups and individual cases which are challenging the Treatment of Part C Days as appealed from the Final Rule. On December 6, 2023, QRS filed 13 appeal requests on behalf of different CIRP groups and individual providers concerning the final rule that the Secretary of Health and Human Services ("Secretary") published in the June 9, 2023 Federal Register ("June 2023 Final Rule") as it relates to the QRS Providers' yet-to-be-finalized FY 2007-2014 Medicare disproportionate share hospital ("DSH") reimbursement.[1]

In the June 2023 Final Rule, the Secretary adopted and finalized its policy to include Part C days in the SSI fraction as used in the DSH calculation for Part C discharges occurring prior to October 1, 2013 and applied this policy *retroactively* to certain open fiscal years to which this policy would appeal.

The Providers in these appeals all involve fiscal years ranging from 2007 to 2014. The ***sole*** issue in each of these appeals is "whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, retroactive final rule issued by the Centers for Medicare & Medicaid Services ("CMS"), which is binding on the Medicare Administrative Contractor ("MAC"), or whether such final rule is illegal and cannot be enforced."[2] The QRS Groups challenge the procedural and substantive validity of the policy adopted and finalized in the June 2023 Final Rule.[3]

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] Issue Statement at 1 in Case No. 24-0416GC. Each of the Issue Statements in the 13 QRS appeals referenced in this decision are materially identical.
[3] 88 Fed. Reg. 37772 (June 9, 2023).

Significantly, the Providers' appeal requests in these cases suggest that they may not have a right to appeal since "Certain of the referenced providers have this issue [being appealed here] pending in [another] appeal that was remanded to the MAC." Notwithstanding, they have not provided ***any*** explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included **any** information on the other "pending . . . appeal that was remanded to the MAC," as **they allege** in their appeal requests*. As explained below, it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

Issue in Dispute

QRS is the group representative for these 13 cases filed on December 6, 2023. Each case has the same issue statement, which reads:

> The issue is whether Part C days are properly included in the denominator of the Medicare Fraction per a June 9, 2023, retroactive final rule issued by the Centers for Medicare & Medicaid Services (CMS), which is binding on the Medicare Administrative Contractor (MAC), or whether such final rule is illegal and cannot be enforced.
>
> The Provider appeals [Providers appeal] the Secretary's determination, which it calls a "final action," embodied in a [June 9, 2023] retroactive final rule, that requires Part C Days to be included in the Medicare Fraction of the disproportionate payment percentage for discharges occurring prior to October 1, 2013 ("the Part C Days Final Rule"). The Part C Days Final Rule became effective on August 8, 2023. The Provider challenges the procedural and substantive validity of the Part C Days Final Rule. Specifically, the Provider asserts [Providers assert] that the Part C Days Final Rule is procedurally invalid the retroactive nature of the rule violates the rulemaking provisions of the Social Security Act and the Administrative Procedure Act, and is contrary to the D.C. Circuit's opinion in *Northeast Hospital v. Sebelius*, and established precedent regarding the applicability of a pre-existing rule when a later rule is vacated (as was the 2004 final rule on Part C days). The Part C Days Final Rule is substantively invalid because it is arbitrary and capricious. Specifically, the Part C Days Final Rule is arbitrary and capricious because CMS did acknowledge that putting Part C Days in the Medicare Fraction was a departure from its policy or practice prior to the vacated 2004 rule. The Part C Days Final Rule also failed to account for hospitals' reliable interest on the pre-2004 final rule practice or policy, and also failed to recognize the enormous adverse financial impact on hospitals due to the change from the pre-2004 final rule practice or policy.

****

> ***Certain of the referenced providers have this issue pending in an appeal(s) that was remanded to the MAC.*** *However, any such remands preceded the Part C Days Final Rule and this appeal is limited to challenging the Part C Days final rule.* Moreover, it is not clear whether the Provider(s) will have full appeal rights following any decision upon remand. That is, it is not clear whether the Provider(s) will be afforded the opportunity to challenge the legality of the Part C Days Final rule if, for example: (a) there is no change in the Providers' Disproportionate Payment Percentage (DPP) in the MAC's determination following remand because Part C days were placed in the Medicare Fraction originally; or (b) there is a positive change in the Providers'] DPP for other reasons (such as the addition of Medicaid eligible days) but the DPP would have been even greater had Part C days not been included in the Medicare Fraction. For this reason, out of an abundance of caution the Provider(s) brings(bring) this challenge to the Part C Days Final Rule at this time.[4]

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[5] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[6]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[7] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[8]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[9] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying

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[4] Issue Statement at 1,3 in Case No. 24-0416GC (emphasis added). Each of the Issue Statements in the 13 QRS appeals referenced in this decision are identical.
[5] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[6] *Id.*
[7] *See* 42 U.S.C. § 1395ww(d)(5).
[8] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).

hospital.[10] The DPP is defined as the sum of two fractions expressed as percentages.[11] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[12]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[13]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[14]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[15]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

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

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[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[12] (Emphasis added.)
[13] 42 C.F.R. § 412.106(b)(2)-(3).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(4).

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[16] 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].[17]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[18]

With the creation of Medicare Part C in 1997,[19] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under 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.[20]

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[16] of Health and Human Services.
[17] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[18] *Id.*
[19] 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. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[20] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

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 . . . .*[21]

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."[22] 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.*[23]

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

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.[24] In that publication the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical

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[21] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[22] 69 Fed. Reg. at 49099.
[23] *Id.* (emphasis added).
[24] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).

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).[25] 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, the Secretary 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."[26]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[27]
In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] 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.[29] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[30] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[31] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[32] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[33] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no

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[25] *Id*. at 47411.
[26] 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).
[27] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *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.").
[30] *Id.* at 2011.
[31] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[32] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[33] 139 S. Ct. 1804 (2019).

formal rule in place.[34] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[35] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[36]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[37] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[38]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[39] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[40]

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[34] *Id.* at 1817.
[35] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[36] 139 S. Ct at 1814.
[37] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[38] CMS Ruling 1739-R at 1-2.
[39] 88 Fed. Reg. 37772 (June 9, 2023).
[40] *Id.* at 37775 (emphasis added).

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[41]

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because they failed to appeal from a final determination, their appeals are premature, and their appeal requests failed to meet the content requirements for a request for Board hearing.

A. The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

In their appeal requests, the Providers allege (without providing any proof) "certain of the referenced providers have this issue pending in an appeal(s) that was remanded to the MAC." The Providers state out of an abundance of caution they have brought this appeal as they are unsure about their appeal rights for these cases *allegedly* pending on remand:

> [I]t is not clear whether the Provider(s) will have full appeal rights following any decision upon remand. That is, it is not clear whether the Provider(s) will be afforded the opportunity to challenge the legality of the Part C Days Final rule if, for example: (a) there is no change in the Providers' Disproportionate Payment Percentage (DPP) in the MAC's determination following remand because Part C days were placed in the Medicare Fraction originally; or (b) there is a positive change in the Providers' DPP for other reasons (such as the addition of Medicaid eligible days) but the DPP would have been even greater had Part C days not been included in the Medicare Fraction. For this reason, out of an

[41] 88 Fed. Reg. at 37788 (emphasis in original).

> abundance of caution the Provider(s) brings (bring) this challenge to the Part C Days Final Rule at this time.[42]

Notwithstanding the fact that these *other* alleged appeals are still *pending* and involve the *same* issue and fiscal years, the Providers filed appeal requests to establish the instant 13 appeals set forth in **Appendix A** based on their appeal of the finalization of the policy at issue in the June 2023 Final Rule. In filing these appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed. As this is a final rule (as opposed to an NPR or revised NPR), they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) states the following in pertinent part:

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (ii) is dissatisfied with a final determination of the Secretary *as to the amount of the payment* under subsection (b) or (d) of section 1395ww of this title, ...[43]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

Unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[44] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42

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[42] Providers' Issue Statements.

[43] (Bold emphasis in original and italics and underline emphasis added.)

[44] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[45]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[46] Examples of other adjustments to IPPS payment rates that are based, in

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[45] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[46] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
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> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we

whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[47] direct graduate medical education ("GME"),[48] and indirect GME.[49]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[50] Further, as discussed *infra*, each of these Providers have alleged that it has pending before the MAC another appeal of the same Part C days issue; however, it is unclear why the Providers were remanded as alleged (*e.g.*, remanded pursuant to a Court Order vs. remanded pursuant to CMS Ruling 1498-R) and what the parameters of those remands is.

Regardless, the four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue for open and prospective cost reporting periods relating to

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> proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

[47] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).

[48] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").

[49] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At **final** **settlement** of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).

[50] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each*** *applicable cost reporting period* during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[51]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[52]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs****.* Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new

[51] 88 Fed. Reg. at 37774-75 (emphasis added).
[52] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).

action, and *the new or revised **NPRs** will provide hospitals with a **vehicle to appeal** the new final action* even if the Medicare fraction or DSH payment does not change numerically."[53]

4. "*When the Secretary's treatment of Part C days in this final action is reflected **in NPRs and revised NPRs**, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation **by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[54]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (2) would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of an original or revised NPR[55]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[56] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[57]

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[53] *Id.* at 37788 (emphasis added).
[54] *Id.* (emphasis added).
[55] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9,2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.
[56] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").
[57] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[58] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive. *Memorial Hospital* concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[59]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[60] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[61] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has

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Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[58] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, the Providers did not appeal the publication of SSI fractions but rather a final rule adopting and finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy adoption in the June 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

[59] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions.

[60] 2022 WL 888190 at *8.

[61] *Id.* at *9 (emphasis added).

> explained, "*the Secretary ha[s] firmly established '**the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[62]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[63]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . .";[64] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[65]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was promulgated/finalized in the June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[66] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[67] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new*

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[62] *Id.* at *8.
[63] *Id.* at *9.
[64] 795 F.2d at 143 (emphasis added).
[65] *Id.* at 147 (footnote omitted).
[66] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[67] 2022 WL 888190 at *9 (emphasis added).

SSI percentages, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) DSH eligibility for a hospital's prior period that is still open for resolution (whether through issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[68]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[69] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[70] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[71]

B. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was Applicable to Them For the Fiscal Years at Issue.

42 C.F.R. § 405.1835(c) specifies the content requirements for a request for a Board hearing as a group appeal. The Providers allege that the issue in these appeals "is pending in an appeal that was remanded to the MAC." Notwithstanding, they have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included **any** information on the other "pending . . . appeal that was remanded to the MAC" **they allege** in their appeal requests*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in

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[68] *See supra* note 59 (confirming that none of the Providers appealed from the publication of SSI fractions).
[69] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.
[70] 42 C.F.R. § 405.1840(a), (b).
[71] 42 C.F.R. § 405.1837(c).

addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section."

Here, none of the Providers include as part of their appeal requests any documentation relating to the implied *prior* appeals and related remand, notwithstanding: (1) their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above, and (2) the fact that Board Rule 35.3 specifies that evidence must be submitted into the record by a party including evidence from another Board case:

> The Board will ***not*** be responsible for supplementing any record with evidence *from a previous hearing*. All evidence submitted into the record, ***must*** be done by the parties.[72]

Without having the NPR or any additional documentation on the Providers' alleged remand as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, in fact, applicable to the Provider's for the fiscal years at issue (*i.e.*, that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal through the operation of the June 2023 Final Rule). Indeed, if the Providers' alleged remand(s) for the fiscal years at issue is still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals.[73] In this regard, the Board is unable determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. § 405.1837(c) requiring its appeal request demonstrate that each of the Providers satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves a payment determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.

C. Multiple Participants Also Can Be Dismissed For Failure to File A Timely Appeal of the June 2023 Final Rule

QRS directly added the following participants more than 180 days after the publication of the June 2023 Final Rule, as follows, *in 3 different CIRP group cases involving 2010, 2011 and 2012*:

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[72] (Emphasis added.)

[73] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in Board Rule 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

Provider	Prov. No.	FY	Case No.
CHI St. Vincent Hosp. Hot Springs	04-0026	2010	24-0416GC
		2011	24-0418GC
Mercy Hospital Fort Smith	04-0062	2010	24-0416GC
		2011	24-0418GC
		2012	24-0420GC

Specifically, QRS directly added each of these participants on February 6, 2024 which is 242 days after the June 2023 Final Rule was published. 62 The Board finds that the direct-add requests (*i.e.*, appeal requests) for the above-5 participants were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (*i.e*., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after* ***notice*** *of the Secretary's final determination.*"[74] The direct-add requests were filed in OH CDMS approximately ***2 months past*** the filing deadline of 180 days after the issuance of the June 2023 Final Rule.

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[75] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[76] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[77] The Board cannot apply a regulation or

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[74] (Emphasis added.)
[75] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these 149 appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.
[76] (Emphasis added.)
[77] *See* 42 C.F.R. § 405.1867.

instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[78] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[79] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[80] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[81]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

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[78] of the Department of Health and Human Services.
[79] 42 U.S.C. § 1306(a).
[80] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").
[81] *See also* 42 C.F.R. Part 401, Subpart B.

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[82]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[83] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[84] Consequently, a provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[85]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[86]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

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[82] (Emphasis added).
[83] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[84] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[85] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[86] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[87]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-listed 5 direct-add requests were not filed with the Board until ***more than 2 months after this deadline*** (specifically February 6, 2024 and, thus, were not timely filed.[88]

Based on the above findings, the Board concludes that the direct-add requests of CHI St. Vincent Hosp. Hot Springs (Prov. No. 04-0026) to be added to Case Nos. 24-0416GC and 24-0418GC and the direct-add requests of Mercy Hospital Fort Smith (Prov. No. 04-0062) to added to Case Nos. 24-0416GC, 24-0418GC, and 24-0420GC failed to meet the claims-filing requirements for a Board hearing request[89] due to the failure of the Providers' to *timely* file their direct-add request to these groups to appeal the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, the Board hereby dismisses them. This is a separate and independent basis to dismiss these 5 participants.

D. Conclusion

The Board finds that: (1) the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); and (2) even if the June 2023

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[87] Emphasis added.

[88] The Providers in these 149 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

[89] *See* 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under 42 C.F.R. § 405.1837(c) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule. Further, the Board also as a separate and independent rational dismisses several participants, as set forth above, from Case Nos. 24-0416GC, 24-0418GC, and 24-0420GC because they failed to meet the claims-filing requirements for a Board hearing request due to their failure to *timely* file their direct-add request to join the relevant group. Based on the foregoing, the Board hereby dismisses the 13 QRS appeals listed in **Appendix A** *in their entirety* and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/7/2024

X Clayton J. Nix

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

Enclosure: Appendix A – Listing of 13 QRS CIRP Groups and Individual Provider Cases

cc: Michael Redmond, Novitas Solutions, Inc. (J-H)
Byron Lamprecht, WPS Government Health Administrators (J-5)
John Bloom, Noridian Healthcare Solutions, c/o CGS Administrators (J-F)
Jacqueline Vaughn, Office of the Attorney Advisor
Wilson Leong, FSS

APPENDIX A
Listing of 13 QRS CIRP Group and Individual Cases

24-0416GC	Mercy Health System CY 2010 Treatment of Part C Days Final Rule CIRP Group
24-0418GC	Mercy Health System CY 2011 Treatment of Part C Days Final Rule CIRP Group
24-0420GC	Mercy Health System CY 2012 Treatment of Part C Days Final Rule CIRP Group
24-0421GC	Mercy Health System CY 2014 Treatment of Part C Days Final Rule CIRP Group
24-0424	Skagit Valley Hospital (50-0003), FFY 2007
24-0427	Skagit Valley Hospital (50-0003), FFY 2008
24-0429	Skagit Valley Hospital (50-0003), FFY 2009
24-0430	Skagit Valley Hospital (50-0003), FFY 2010
24-0431	Skagit Valley Hospital (50-0003), FFY 2011
24-0433	Skagit Valley Hospital (50-0003), FFY 2012
24-0434	Skagit Valley Hospital (50-0003), FFY 2013
24-0436	Mercy Hospital Washington (26-0052), FFY 2013
24-0437	Mercy Hospital Lebanon (26-0059), FFY 2009

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Douglas Lemieux
Kaiser Foundation Health Plan and Hospitals
393 E Walnut St
Pasadena, CA 91188

RE: ***Notice of Dismissal – Updated Rationale***
Kaiser Foundation Standardized Amount CIRP Group Cases
Case Nos. 21-1497GC, *et al.* (*see* **Appendix A** listing 3 group cases)

Dear Mr. Lemieux:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the three (3) above-referenced common issue related party ("CIRP") group cases relating to the standardized amounts used in federal rates for the inpatient prospective payment system ("IPPS") during federal fiscal year ("FFY") 1984, the initial year of IPPS. The Medicare Contractor has filed Jurisdictional Challenges in all of those group cases. As set forth below, the Board has determined that, consistent with 42 U.S.C. §§ 1395ww(d)(7) and 1395oo(g)(2) and 42 C.F.R. § 405.1840(b), it lacks substantive jurisdiction over the appealed issue and is therefore dismissing all three (3) CIRP group cases in their entirety. This determination is consistent with its prior dismissal determinations in other cases involving the same issue where the Board found no *substantive* jurisdiction;[1] however, in response to the additional briefing on this issue by other parties, the Board's decision has been updated to clarify and confirm that the federal rates for FFY 1986 and subsequent FFYs used the FFY 1985 budget neutrality-adjusted federal rates.

In summary, the Board finds that it lacks substantive jurisdiction over the issue raised in these appeals. The standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base rate that was set *using 1981 data*.[2] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably*

[1] Prior Board dismissal determinations of the issue in the instant group appeals include but are not limited to: Board dec. dated Apr. 6, 2023 (lead Case No. 19-0233GC); Board dec. dated Dec. 14, 2023 (lead Case No. 23-0695GC); Board dec. dated Jan. 23, 2024 (lead Case No. 19-1094GC); Board dec. dated Jan. 24, 2024 (lead Case No. 23-1522GC); and Board dec. dated Jan. 31, 2024 (lead Case No. 19-0847GC). These jurisdictional decisions are posted on the Board's website, by the relevant year and month, at https://www.cms.gov/medicare/regulations-guidance/provider-reimbursement-review-board/list-prrb-jurisdictional-decisions.

[2] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts

intertwined with those applicable budget neutrality adjustments.[3] Indeed, the standardized amounts were too high for FFYs 1984 and 1985 and the budget neutrality adjustments applied to those years reduced the standardized amounts (reduced by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985) and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on 1981 data).[4] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments, the Board may not review the standardized amount used for the FFYs appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates. Accordingly, the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purposes of future FFYs*,[5] because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.[6]

Background:

Kaiser Foundation Health Plan and Hospitals ("Providers' Representative") represents a number of providers in common issue related party ("CIRP") groups which are challenging the IPPS standardized amount. The Medicare Contractor filed a Jurisdictional Challenge covering three (3) group cases.[7] The Providers' Representative failed to file a timely response. The group issue statements and jurisdictional challenge thereto for all three (3) cases are materially identical and can be considered together.

The issue presented is:

> Whether the Hospital's FY 2019 Inpatient Prospective Payment System ("IPPS") payments were incorrectly low because they were based on 1981 discharge data that was improperly incorporated into the base payment rates for IPPS hospitals, thereby causing Medicare IPPS underpayments in all subsequent years.[8]

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[3] *See infra* note 49 (citing to decisions that discuss similar circumstances involving Medicare provisions found to be inextricably tied to certain other provisions for which Congress precluded administrative and judicial review).
[4] *See infra* note 33 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).
[5] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns.
[6] *See also supra* note 2 outlining additional intervening adjustments that could be adversely impacted by the relief being sought by the Providers, thereby raising other similar IPPS integrity concerns that could potentially serve as an alternative rationale.
[7] *See* **Appendix A**.
[8] *E.g.,* Case 21-1497GC, Group Issue Statement (Sept. 10, 2018).

Procedural Background:

A. Appealed Issue

In the Providers' group issue statements, they explain that under the IPPS, hospitals are paid a fixed amount for each Medicare beneficiary that they treat. The fixed amount is calculated each year starting with a base rate. Their appeals challenge that base rate, arguing that the data used to establish the initial rate payable per discharge resulted in an understated payment rate. CMS opted to use 1981 as a "base year" to calculate these rates, and thus data was collected from hospitals' 1981 cost reports to determine average costs for each discharge category. The data was adjusted for inflation and standardized, but the Providers argue that the initial calculation of this standardized amount continues to serve as the base for all future calculations. Since the Providers allege this initial calculation was understated, they argue that the calculation for each subsequent year has also been understated.[9]

The Providers claim that the data sources used in collecting the 1981 data did not distinguish between patients who were discharged from the hospital, and patients who were transferred to another hospital or facility. They state that CMS views transfers as distinct from discharges, but in calculating the average cost per discharge using the 1981 data, CMS erroneously included transfers in the total number of discharges, thereby inflating the denominator of the cost to discharge ratio. They claim that CMS has acknowledged this error in at least one other context (*i.e.*, during the implementation of the capital PPS), and that this error was the reason for certain DRG weight recalibrations, but that CMS failed to fully correct the flawed Standardized Amount.[10]

In each case, the Providers are challenging the applicable FFY IPPS rates as set forth in the Federal Register. They argue the appeals are not barred by the "predicate facts" provision of 42 C.F.R. § 405.1885 and that there is no impediment to CMS correcting its erroneous data to remediate the flawed Standardized Amount. They claim that the average cost per discharge should not include transfers, that CMS has acknowledged this as well as the fact that certain Standardized Amounts erroneously included transfers, and that this practice violates the Medicare Act.

B. Jurisdictional Challenges

The Medicare Contractor filed a challenge covering three (3) different group cases.[11] The Medicare Contractor argues that the merits of the appealed issue are illegitimate, but more importantly, that the Board lacks subject matter jurisdiction and need not even address the merits of the issue. It references the Board's April 6, 2023 decision dismissing three (3) different CIRP group appeals concerning the same issue. The Medicare Contractor argues the Board should apply the same rationale and find that 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative

[9] *See e.g.*, *id*.
[10] *See e.g.,* PRRB Case No. 22-0926GC, Providers' Preliminary Position Paper at 2.
[11] *See* **Appendix A** for a complete list of cases impacted.

review of the base year standardized amounts. It also claims that budget neutrality adjustments after the base year amount was calculated have corrected any potential errors from prior years, and that the data shows the base year was, in fact, initially set too high (rather than understated).

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[12] Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." However, in this case, the Board, by its own motion, filed a scheduling order which required the Providers' response by November 21, 2023. The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. As advised in the Board's September 28, 2023 scheduling order, failure of the Provider's representative to file a response would result in the Board making a jurisdictional determination with the information contained in the record.

Board Decision:

As described more fully below, the Board finds that it lacks substantive jurisdiction over each of the three (3) groups because: (1) the initial IPPS standardized amounts set for FFY 1984[13] are ***inextricably*** tied to the FFY 1984 and 1985 budget neutrality adjustments to the "applicable percentage increases" for IPPS[14]; (2) the FFY 1985 budget neutrality-adjusted rates were used to determine the rates for FFY 1986 and, thus, became embedded into the rates determined for subsequent FFYs; and (3) 42 U.S.C. § 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments. Further, the fact that the Secretary's budget neutrality adjustment to the FY 1984 Federal Rates was 0.970[15] demonstrates that, contrary to the Providers' assertions, the initial standardized amount was ***not*** understated but rather was *overstated* by a factor of 0.030 (*i.e.*, 1.000 – 0.970).

A. Statutory Background on IPPS and the Standardized Amount Used in IPPS Rates

Part A of the Medicare program covers "inpatient hospital services." Since October 1, 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the IPPS.[16] Under IPPS, Medicare pays a prospectively-determined rate per eligible discharge, subject to certain payment adjustments.[17]

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[12] Board Rule 44.4.3, v. 3.1 (Nov. 2021).
[13] The Board notes that, initially, there was not just one standardized amount. Rather there were 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation and each of these 20 rates is further divided into a labor and nonlabor portion. *See* 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[14] 42 U.S.C. § 1395ww(e) is entitled "Proportional adjustments in applicable percentage increases." The 1984 and 1985 budget neutrality adjustments are set forth is § 1395ww(e)(1)(B) which is cross-referenced for 1984 IPPS rates at § 1395ww(d)(2)(F) and for 1985 IPPS rates at § 1395ww(d)(3)(C).
[15] In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970. 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[16] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[17] *Id.*

In order to implement IPPS, "the statute require[d] that the Secretary determine national and regional adjusted DRG prospective payment rates for each DRG to cover the operating costs of inpatient hospital services."[18] The methodology for arriving at the appropriate rate structure is located at 42 U.S.C. § 1395ww(d)(2) and "requires that certain ***base period*** *cost data* be developed and modified in several specified ways (*i.e.*, inflated, standardized, grouped, and adjusted) resulting in 20 average standard amounts per discharge according to urban/rural designation in each of the nine census divisions and the nation."[19] Section 1395ww(d)(2)(A) requires that the Secretary determine a "base period" operating cost per discharge using the most recent cost reporting period for which data are available:

> (II) DETERMINING ALLOWABLE INDIVIDUAL HOSPITAL COSTS FOR BASE PERIOD.—The Secretary shall determine the allowable operating costs per discharge of inpatient hospital services for the hospital for the most recent cost reporting period for which data are available.

Consistent with these statutory provisions, the Secretary used Medicare hospital cost reports for reporting periods ending in 1981 and set the 1984 "base period" operating cost per discharge amount using the 1981 operating costs per discharge amount *updated* by an inflationary factor.[20] The Providers dispute how the Secretary determined "discharges" and allege that the Secretary improperly treated transfers as discharges for purposes of this calculation.

The Secretary then "standardized" the FFY 1984 base period operating cost per discharge using the process prescribed at 42 U.S.C. § 1395ww(d)(2)(c). The standardization process removed the effects of certain variable costs from the cost data, including (but not limited to) excluding costs associated with indirect medical education costs, adjusting for variations in average hospital wage levels, and adjusting for variations in case mix among hospitals.

The initial standardized amounts have been annually adjusted and/or updated. However, contrary to the characterization in the D.C. Circuit's 2011 decision in *Saint Francis Med. Ctr. v. Azar* ("*Saint Francis*"), the standardized amount is not adjusted each year simply for inflation.[21] Significantly, some of these annual adjustments were required to be *budget neutral* and are not subject to administrative review and others are discretionary. In particular, 42 U.S.C. § 1395ww(e)(1)(B) provides the budget neutrality adjustment for "the applicable percentage increases" to the standardized amounts for 1984 and 1985 and states, in pertinent part:

> **(e) Proportional adjustments in *applicable percentage increases***
>
> (1) . . . .

[18] 48 Fed. Reg. 39752, 39763 (Sept. 1, 1983).
[19] *Id.* (emphasis added).
[20] *Id*. at 39763-64.
[21] 894 F.3d 290, 291 (D.C. Cir. 2011). *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (B) For discharges occurring in fiscal year 1984 or fiscal year 1985, the Secretary shall provide under subsections (d)(2)(F) and (d)(3)(C) for such equal proportional adjustment *in each of the average standardized amounts* otherwise computed for that fiscal year as may be necessary to assure that—
>
> > (i) the aggregate payment amounts otherwise provided under subsection (d)(1)(A)(i)(II) and (d)(5) for that fiscal year for operating costs of inpatient hospital services of hospitals (excluding payments made under section 1395cc(a)(1)(F) of this title),
>
> *are not greater or less than*—
>
> > (ii) the DRG percentage (as defined in subsection (d)(1)(C)) of *the payment amounts which would have been payable for such services* for those same hospitals for that fiscal year under this section *under the law as in effect before April 20, 1983* (excluding payments made under section 1395cc(a)(1)(F) of this title).[22]

The Secretary implemented the above budget neutrality provisions at 42 C.F.R. §§ 412.62(i) and 412.63(v) for the 1984 rate year and 1985 rate year respectively. Specifically, § 412.62(i) provides the following instruction for maintaining budget neutrality for the 1984 Federal IPPS rates:

> (i) *Maintaining budget neutrality.* (1) CMS adjusts each of the **reduced standardized amounts** determined under paragraphs (c) through (h) of this section as required for fiscal year 1984 so that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for Federal fiscal year 1984) **is not greater or less than** 25 percent of **the payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1984 **under the Social Security Act as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[23]

[22] (Bold emphasis in original and italics and underline emphasis added.) The budget neutrality adjustment at 42 U.S.C. § 1395ww(e)(1)(B) is cross-referenced for 1984 at 1395ww(d)(2)(F) and for 1985 at § 1395ww(d)(3)(C).
[23] (Italics emphasis in original and bold and underline emphasis added.)

Similarly, the regulation at 42 C.F.R. § 412.63(v) provides the following instruction for maintaining budget neutrality for the 1985 Federal rates for IPPS:

> (v) *Maintaining budget neutrality for fiscal year 1985.* (1) For fiscal year 1985, CMS will adjust each of the reduced standardized amounts determined under paragraph (c) of this section as required for fiscal year 1985 to ensure that the estimated amount of aggregate payments made, excluding the hospital-specific portion (that is, the total of the Federal portion of transition payments, plus any adjustments and special treatment of certain classes of hospitals for fiscal year 1985) is **not greater or less** than 50 percent of the **payment amounts that would have been payable** for the inpatient operating costs for those same hospitals for fiscal year 1985 **under the law as in effect on April 19, 1983**.
>
> (2) The aggregate payments considered under this paragraph exclude payments for per case review by a utilization and quality control quality improvement organization, as allowed under section 1866(a)(1)(F) of the Act.[24]

Essentially, Congress mandated that the Secretary/CMS adjust the standardized amounts for both 1984 and 1985 to ensure that the estimated amount of aggregate payments made under IPPS was not *greater than **or** less than* what would have been payable for inpatient operating costs for the same hospitals under the prior reimbursement system (*i.e.*, reasonable costs subject to TEFRA limits). In other words, pursuant to budget neutrality, the size of the pie, expressed as average payment per case, is prescribed by law to be *no more **and** no less* than what would have been paid had IPPS not been implemented. Significantly, the reference points for maintaining budget neutrality for 1984 and 1985 are ***external*** to IPPS and, thus, ***fixed*** (no greater *and* no less) based on the best data available.[25] Since these points are ***fixed,*** it also means that it is capped (*i.e.*, cannot be increased subsequently outside of the budget neutrality adjustment).

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[24] (Italics emphasis in original and bold and underline emphasis added.)

[25] 48 Fed. Reg. 39752, 39887 (Sept. 1, 1983) provides the following discussion supporting the Board's pie concept:

> Section 1886(e)(1) of the Act requires that, for Federal fiscal years 1984 and 1985, prospective payments be adjusted so that aggregate payments for the operating costs of inpatient hospital services are neither more nor less than we estimate would have been paid under prior legislation for the costs of the same services. To implement this provision, we are making actuarially determined adjustments to the average standardized amounts used to determine Federal national and regional payment rates and to the updating factors used to determine the hospital-specific per case amounts incorporated in the blended transition payment rates for fiscal years 1984 and 1985. Section 1886(d)(6) of the Act requires that the annual published notice of the methodology, data and rates include an explanation of any budget neutrality adjustments. This section is intended to fulfill that requirement.
>
> Although, for methodological reasons, the budget neutrality adjustment is calculated on a per discharge basis, it should be emphasized that the ultimate comparison is between the aggregate payments to be made under the prospective payment system and the aggregate payments that

This conclusion is supported by the fact that the normal annual inflation adjustments to the standardized amount provided for in IPPS apply only for FY 1986 forward, as set forth in 42 U.S.C. § 1395ww(b)(3)(B)(3)(i) and cross referenced in § 1395ww(d)(3)(A). Specifically, 42 U.S.C. § 1395ww(b)(3)(B)(i) (2018) defines the term "applicable percentage increase" starting with fiscal year 1986 (as opposed to 1984):

> (B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—
>
> (I) ***for fiscal year 1986***, 1/2 percent,
>
> (II) for fiscal year ***1987***, 1.15 percent,
>
> (III) for fiscal year ***1988***, 3.0 percent for hospitals located in a rural area, 1.5 percent for hospitals located in a large urban area (as defined in subsection (d)(2)(D)), and 1.0 percent for hospitals located in other urban areas,
>
> (IV) for fiscal year ***1989***, the market basket percentage increase minus 1.5 percentage points for hospitals located in a rural area, the market basket percentage increase minus 2.0 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 2.5 percentage points for hospitals located in other urban areas,
>
> (V) for fiscal year ***1990***, the market basket percentage increase plus 4.22 percentage points for hospitals located in a rural area, the market basket percentage increase plus 0.12 percentage points for hospitals located in a large urban area, and the market basket percentage increase minus 0.53 percentage points for hospitals located in other urban areas,
>
> (VI) for fiscal year ***1991***, the market basket percentage increase minus 2.0 percentage points for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.7 percentage point for hospitals located in a rural area,
>
> (VII) for fiscal year ***1992***, the market basket percentage increase minus 1.6 percentage points for hospitals in a large urban or other

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would have been incurred under the prior legislation. Therefore, changes in hospital behavior from that which would have occurred in the absence of the prospective payment system are required to be taken into account in determining the budget neutrality adjustment if they affect aggregate payment. For example, any expectation of increased admissions beyond the level that would have occurred under prior law would have to be considered in the adjustment. To assist in making the budget neutrality adjustment for, and take account of, fiscal year 1985, HCFA will monitor for changes in hospital behavior attributable to the new system.

urban area, and the market basket percentage increase minus 0.6 percentage point for hospitals located in a rural area,

(VIII) for fiscal year ***1993***, the market basket percentage increase minus 1.55 percentage point for hospitals in a large urban or other urban area, and the market basket percentage increase minus 0.55 1 for hospitals located in a rural area,

(IX) for fiscal year ***1994***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and the market basket percentage increase minus 1.0 percentage point for hospitals located in a rural area,

(X) for fiscal year ***1995***, the market basket percentage increase minus 2.5 percentage points for hospitals located in a large urban or other urban area, and such percentage increase for hospitals located in a rural area as will provide for the average standardized amount determined under subsection (d)(3)(A) for hospitals located in a rural area being equal to such average standardized amount for hospitals located in an urban area (other than a large urban area),

(XI) for fiscal year ***1996***, the market basket percentage increase minus 2.0 percentage points for hospitals in all areas,

(XII) for fiscal year ***1997***, the market basket percentage increase minus 0.5 percentage point for hospitals in all areas,

(XIII) for fiscal year ***1998***, 0 percent,

(XIV) for fiscal year ***1999***, the market basket percentage increase minus 1.9 percentage points for hospitals in all areas,

(XV) for fiscal year ***2000***, the market basket percentage increase minus 1.8 percentage points for hospitals in all areas,

(XVI) for fiscal year ***2001***, the market basket percentage increase for hospitals in all areas,

(XVII) for fiscal year ***2002***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XVIII) for fiscal year ***2003***, the market basket percentage increase minus 0.55 percentage points for hospitals in all areas,

(XIX) for each of fiscal years ***2004*** through ***2006***, subject to clause (vii), the market basket percentage increase for hospitals in all areas; and

> (XX) ***for each subsequent fiscal year***, subject to clauses (viii), (ix), (xi), and (xii), the market basket percentage increase for hospitals in all areas.[26]

The "applicable percentage increase" as defined in § 1395ww(b)(3)(B) is incorporated into § 1395ww(d)(3)(A), as it relates to updating of the standardized amount:

> **(B) UPDATING** PREVIOUS STANDARDIZED AMOUNTS.—
>
> (i) For discharges occurring in a fiscal year beginning ***before*** October 1, 1987, the Secretary shall compute an average standardized amount for hospitals located in an urban area and for hospitals located in a rural area within the United States and for hospitals located in an urban area and for hospitals located in a rural area within each region, *equal to the respective average standardized amount computed for the previous fiscal year under paragraph (2)(D) or under this subparagraph*, ***increased for the fiscal year involved by the applicable percentage increase under subsection (b)(3)(B)***. With respect to discharges occurring on or after October 1, 1987, the Secretary shall compute urban and rural averages on the basis of discharge weighting rather than hospital weighting, making appropriate adjustments to ensure that computation on such basis does not result in total payments under this section that are greater or less than the total payments that would have been made under this section but for this sentence, and making appropriate changes in the manner of determining the reductions under subparagraph (C)(ii).
>
> (ii) For discharges occurring in a fiscal year beginning on or after October 1, 1987, and ending on or before September 30, 1994, the Secretary shall compute an average standardized amount for hospitals located in a large urban area, for hospitals located in a rural area, and for hospitals located in other urban areas, within the United States and within each region, equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (iii) For discharges occurring in the fiscal year beginning on October 1, 1994, the average standardized amount for hospitals located in a rural area shall be equal to the average standardized

[26] (Emphasis added.)

> amount for hospitals located in an urban area. For discharges occurring on or after October 1, 1994, the Secretary shall adjust the ratio of the labor portion to non-labor portion of each average standardized amount to equal such ratio for the national average of all standardized amounts.
>
> (iv)(I) Subject to subclause (II), for discharges occurring in a fiscal year beginning on or after October 1, 1995, the Secretary shall compute an average standardized amount for hospitals located in a large urban area and for hospitals located in other areas within the United States and within each region equal to the respective average standardized amount computed for the previous fiscal year under this subparagraph increased by the applicable percentage increase under subsection (b)(3)(B)(i) with respect to hospitals located in the respective areas for the fiscal year involved.
>
> (II) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area within the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

Thus, while 42 U.S.C. § 1395ww(d)(2) provides the methodology for calculating the standardized amount to be used for each year, and that the amount is subject to the "applicable percentage increase" under subsection (b)(3)(B) *for years after 1984*, it remains that it is not always a simple inflationary or market basket adjustment. In particular, the FFY 1984 and 1985 budget neutrality adjustments (as referenced in § 1395ww(d)(2)(F) and in § 1395ww(d)(3)(C)) were the applicable percentage increases for FFYs 1984 and 1985 and, as described below, those adjustments are not administratively reviewable. Further, as discussed *infra*, it is clear that the Secretary has interpreted 42 U.S.C. § 1395ww(d)(3)(A)(i) to require that the FFY 1985 budget neutrality-adjusted rates be used in determining the rates for FFY 1986 and subsequent FFYs. This is reflected in the following excerpt from 42 C.F.R. § 405.473(c) as initially adopted in the September 3, 1983 final rule:

> (c) *Federal rates for fiscal years after Federal fiscal year 1984.*
>
> ****
>
> (2) *Updating previous standardized amounts.*
>
> (i) *For fiscal year 1985*. HCFA will compute an average standardized amount for each group of hospitals described in paragraph (b)(5) of this section . . . equal to the respective adjusted

average standardized amount computed for fiscal year 1984 under paragraph (b)(7) of this section—

(A) Increased for fiscal year 1985 by the applicable percentage increase under § 405.463(c);

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475; and
(D) **Adjusted for budget neutrality under paragraph (c)(4) of this section**.

(ii) **For fiscal year 1986** and thereafter, **HCFA will compute an average standardized amount** for each group of hospitals described in paragraph (b)(5) of this section, **equal to the respective adjusted average standardized amounts computed for the previous fiscal year**—

(A) Increased by the applicable percentage increase determined under paragraph (c)(3) of this section; and

(B) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements.

(C) Reduced by a proportion equal to the proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments which are additional payment amounts attributable to outlier cases under § 405.475.

(3) *Determining applicable percentage changes for fiscal year 1986 and following*. The Secretary will determine for each fiscal year (beginning with fiscal year 1986) the applicable percentage change which will apply for purposes of paragraph (c)(2)(ii) of this section as the applicable percentage increase for discharges in that fiscal year, and which will take into account amounts the Secretary

> believes necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality. In making this determination, the Secretary will consider the recommendations of the Prospective Payment Assessment Commission.[27]

B. Jurisdictional Findings -- 42 U.S.C. § 1395ww(d)(7)(A) Precludes Administrative Review of the Base Year Standardized Amounts

The Providers essentially are challenging the standardized amount used in the IPPS rates for several FFYs claiming that the Secretary improperly treated transfers as discharges when using 1981 cost report data to determine the initial FFY 1984 base cost per discharge which, in turn, was standardized to arrive at the FFY 1984 standardized amounts. More specifically, the Providers maintain that, the understatement of the standardized amount in the FFY 1984 IPPS Final Rule caused a corresponding underpayment in IPPS payments in FFY 1984 ***and every FFY***

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[27] 48 Fed. Reg. at 39823 (italics emphasis in original and bold and underline emphasis added). This provision was later moved to 42 C.F.R. § 412.63(c)(2022) which states in pertinent part:

> (c) *Updating previous standardized amounts*.
>
> ****
>
> (2) Each of those amounts is equal to the respective adjusted average standardized amount computed for fiscal year 1984 under §412.62(g)—
> (i) Increased for fiscal year 1985 by the applicable percentage increase in the hospital market basket;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements;
> (iii) Reduced by a proportion equal to the proportion (estimated by CMS) of the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part; and
> (iv) **Adjusted for budget neutrality under paragraph (h) of this section**.
> (3) ***For fiscal year 1986*** *and thereafter*. CMS computes, for urban and rural hospitals in the United States and for urban and rural hospitals in each region, average standardized amount equal to the respective **adjusted average standardized amounts computed for the previous fiscal year**—
> (i) Increased by the applicable percentage increase determined under paragraphs (d) through (g) of this section;
> (ii) Adjusted by the estimated amount of Medicare payment for nonphysician services furnished to hospital inpatients that would have been paid under Part B were it not for the fact that such services must be furnished either directly by hospitals or under arrangements; and
> (iii) For discharges occurring on or after October 1, 1985 and before October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments based on the total amount of prospective payments that are additional payment amounts attributable to outlier cases under subpart F of this part, and for discharges occurring on or after October 1, 1986, reduced by a proportion (estimated by HCFA) of the amount of payments that, based on the total amount of prospective payments for urban hospitals and the total amount of prospective payments for rural hospitals, are additional payments attributable to outlier cases in such hospitals under subpart F of this part.

thereafter *because the standardized amount for all IPPS payments for every FFY are based on CMS's calculation of the FFY 1984 standardized amount*.[28]

The published standardized amount for each FFY in these appeals reflects the prior year's standardized amount plus "the applicable percentage increase" as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i) (as referenced in 42 U.S.C. § 1395ww(d)(3)(A)) *as well as other potential adjustments*. Significantly, the "applicable percentage increase[s]" for 1984 forward are ***not*** always simply a cost inflation adjustment or other similar percentage adjustment. To this point, for the first two (2) years of IPPS, Congress mandated that the budget neutrality adjustments for FFYs 1984 and 1985 serve as the "applicable percentage increase" for those years. As a result, the IPPS rates that the Secretary used *for the very first year of IPPS* and then the second year of IPPS were adjusted for budget neutrality. For FFYs 1986 and forward, Congress provided for an "applicable percentage increase" in 42 U.S.C. § 1395ww(b)(3)(B)(i) as referenced in 42 U.S.C. § 1395ww(d)(3)(A). In addition, there are other *permanent* adjustments (*i.e.*, adjustments not for that year only but that also apply on a going-forward basis) to the standardized amount that have occurred in other years outside of the "applicable percentage increase."[29] Thus, the standardized amount for a particular year is an amalgamation that builds upon the prior year's standardized amount and then adds additional adjustments for the current year. As noted *supra* and discussed more *infra*, the Secretary has used the FFY 1985 budget neutrality-adjusted rates for determining the FFY 1986 rates and those for subsequent FFYs.

The Providers are, essentially, seeking to peel back the amalgamated standardized amount for each applicable FFY *and, thus, reach back* ***more than 30 years*** to increase the initial FFY 1984 base rate that was used to set the initial FFY 1984 standardized amount***s***. They would then incorporate the alleged increased base rate into the FFY 1984 standardized amount***s*** and then simply carry or flow that *increase forward 35 years*. However, in order to peel the amalgamated standardized amounts for the FFYs at issue (singular[30]) *as used in the IPPS rates for each FFY* back to the initial standardized amount***s*** (plural[31]) used in FFY 1984, and then carry/flow any change forward *to the FFY at issue*, the Providers would have to pass through the FFY 1984 and 1985 budget neutrality adjustments which were the only "applicable percentage increase[s]" for those years. However, they cannot do so because the budget neutrality adjustments had the effect of ***fixing*** the pie for FFYs 1984 and 1985 to (*i.e.*, no more ***and*** no less than) the aggregate amounts that would have been paid had IPPS not been implemented.[32] More specifically, the amalgamated standardized payment amount for each FFY at issue reflects the *fixed* FFY 1985 budget neutrality adjustment (and not the initial FFY 1984 standardized amount since the standardized amounts for FFYs 1984 and 1985 were each adjusted for budget neutrality and became *fixed* for purposes of

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[28] *See e.g.*, PRRB Case 21-1497GC, Group Issue Statement.
[29] *See* **Appendix B.**
[30] *See supra* note 15 accompanying text.
[31] *See id.*
[32] *See, e.g.,* 48 Fed. Reg. 39752, 39805 (Sept. 1, 1983) (stating: "Hospital Impact—During its first two years, aggregate payments under the prospective payment system will be adjusted, in accordance with Section 1886(e)(1) of the Act, to be "budget neutral"; that is, so that aggregate payments under the prospective payment system, including outlier payments, exceptions, and adjustments, will be neither more nor less than the estimated payment amounts to affected hospitals that would have resulted under the Social Security Act as in effect before April 20,1983.").

subsequent years as a result of those budget neutrality adjustments). Thus, in the Board's view, the Providers cannot get back to the FFY 1984 standardized amounts without first passing through the FFY 1984 and 1985 budget neutrality adjustments. Regardless, the Providers would not be able to flow forward any adjustments made to the FFY 1984 standardized amounts to FFYs after FFY 1985 because:

> (1) they, again, would not be able to get through the FFY 1984 and 1985 budget neutrality adjustments that Congress otherwise ***fixed*** to an external point (no greater and no less); and
>
> (2) the IPPS rates paid for FFYs 1984 and 1985 are based on standardized amounts that were adjusted downwards as a result of the budget neutrality adjustment for FFY 1984 and also for FFY 1985 (*see* discussion below in Sections B.1 and B.2).[33]

Accordingly, the Board finds that the Providers challenge to the standardized amounts at issue are *inextricably* tied to the budget neutrality adjustments made for FFY 1984 and 1985.[34]

Furthermore, Congress has precluded Board (and judicial) review of the FFY 1984 and 1985 budget neutrality adjustments. Specifically, 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and juridical review of the neutrality adjustment at § 1395ww(e)(1):

> (7) There shall be no administrative or judicial review under section 1395oo of this title or otherwise of—

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[33] Indeed, the FY 1986 IPPS Final Rule included an example where the Secretary recognized an adjustment to the budget neutrality adjustments would be impacted by the removal of nurse anesthetists costs and confirmed that the adjustments to the standardized amounts had already taken this removal into account:

> c. Nonphysician anesthetist costs. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987.
>
> We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, *because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts*. (See 49 FR 34794; August 31, 1984). ***Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment***. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.

50 Fed. Reg. at 35708 (emphasis added). *See also* 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (stating: "In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, *it was incorporated in the overall* ***budget neutrality adjustment*** (50 FR 35708). Therefore, because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived, we did not propose to make further adjustments to the average standardized amounts for FY 1988.").

[34] The Board notes that the D.C. Circuit's decision in *Saint Francis* is not applicable to the 1984 and 1985 budget neutrality adjustments given the statutory provision precluding administrative and judicial review of those adjustments. Further, *Saint Francis* did not analyze how the standardized amount is updated annually nor did it make specific legal holdings regarding the standardized amount.

> (A) the determination of the requirement, or the proportional amount, of any adjustment effected pursuant to subsection (e)(1) or the determination of the applicable percentage increase under paragraph (12)(A)(ii), . . .[35]

Similarly, the statute governing Board appeals is located at 42 U.S.C. § 1395oo and states in subsection (g)(2):

> The determinations and other decisions described in section 1395ww(d)(7) of this title shall not be reviewed by the Board or by any court pursuant to an action brought under subsection (f) or otherwise.

Since the FFY 1984 and 1985 budget neutrality adjustments are based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and are not reviewable, the Board finds that the FFYs 1984 and 1985 budget neutrality adjustments effectively fixed the standardized amounts from that point forward for use in the IPPS system.[36]

Indeed, the Secretary's implementation of the fixed FFY 1984 and 1985 budget neutrality adjustments confirms that the Providers' allegation that the standardized rates for ***each FFY at issue*** are somehow understated due to alleged errors in the FFY 1984 base rate is moot.

1. *The Secretary determined that the initial standardized amounts for FFY 1984 were too high and, therefore, reduced the FFY 1984 standardized amounts through the FFY 1984 budget neutrality adjustment as reflected in the **final** FFY 1984 IPPS rates*.

In the interim final rule published on September 1, 1983, the Secretary issued a FFY 1984 budget neutrality adjustment to the FFY 1984 standardized amounts of 0.969:

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[35] With regard to implementing this statutory provision, 48 Fed. Reg. 39752, 39785 (Sept. 1, 1983) states:

> Section 1886(d)(7) of the Act precludes administrative and judicial review of the following:
> —A determination of the requirement, or the proportional amount, of any "budget neutrality" adjustment effected under section 1886(e)(1) of the Act; or
> —The establishment of DRGs, of the methodology for the classification of hospital discharges within DRGs, or of the appropriate weighting factors of DRGs under section 1886(d)(4) of the cost. It was the clear intent of Congress that a hospital would not be permitted to argue that the level of the payment that it receives under the prospective payment system is inadequate to cover its costs. Thus, as discussed above, neither the definition of the different DRGs, their weight in relation to each other, nor the method used to assign discharges to one of the groups is to be reviewable. However, if there is an error in the coding of an individual patient's case, review would be permitted. (See the Report of the Committee on Ways and Means on H.R. 1900, H. Report No. 98-25, (98th Cong., 1st Sess.) 143 (1982).) As noted below, we believe the appropriate review concerning coding errors should be conducted by the entity (i.e., the PSRO/PRO or fiscal intermediary) which made the initial determination.

[36] *See, e.g.,* 48 Fed. Reg. 39752, 39765 (Sept. 1, 1983) (stating "We point out that aside from being technically desirable, the effect of standardizing nonlabor hospital costs in Alaska and Hawaii is to decrease the reduction for budget neutrality stemming from the requirements in section 1886(e)(1)(B) of the Act.").

Section 1886(e)(1) of the Act requires that the prospective payment system result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for fiscal years 1984 and 1985, the prospective payment system should be "budget neutral."

Under the Amendments, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. Section 1886(e)(1)(A) of the Act requires that aggregate payments for the hospital specific portion should equal the comparable share of estimated reimbursement under prior law. **Similarly, section 1886(e)(1)(B) of the Act requires that aggregate reimbursement for the Federal portion of the prospective payment rates plus any adjustments and special treatment of certain classes of hospitals should equal the corresponding share of estimated outlays prior to the passage of Pub. L. 98-21**. Thus, for fiscal year 1984, 75 percent of total projected reimbursement based on the hospital-specific portion should equal 75 percent of total estimated outlays under law as in effect prior to April 20, 1983. Likewise, total estimated prospective payment system outlays deriving from the 25 percent Federal portion, including adjustments and special payment provisions, should equal 25 percent of projected reimbursement under prior laws.

The adjustment of the Federal portion was determined as follows:

- *Step 1*—Estimate total incurred payments for inpatient hospital operating costs for fiscal year 1984 that would have been made on a reasonable cost basis under Medicare prior to Pub. L. 98-21.
- *Step 2*—Multiply total incurred payments by 25 percent, i.e., the Federal portion of total payment amounts for fiscal year 1984.
- *Step 3*—Estimate the Federal portion of total payments that would have been made without adjusting for budget neutrality, but with the adjustment for outlier payments.
- *Step 4*—Add an estimate of total adjustments and payments under special payment provisions to the Federal portion (e.g., outliers, indirect medical education).
- *Step 5*—The difference between the step 2 and step 4 amounts is divided proportionally among the standardized amounts, resulting in the budget neutrality adjusted (standardized) amounts.

> **The resulting adjustment factor for the fiscal year 1984 <u>Federal portion</u> is .969**. Payment amounts of hospitals excluded from the prospective payment system (e.g., psychiatric and children's hospitals) and of hospitals not participating in prospective payment because of their participation in demonstrations and studies were not included in the calculations above.[37]

In the final rule published on January 3, 1984, the Secretary revised the Federal budget neutrality adjustment factor to 0.970 using the same methodology.[38] Significantly, in the January 1984 final rule, the Secretary suggests that, in calculating the budget neutrality adjustment factor, CMS made no attempt to adjust for transfers under IPPS:

> Regarding additional adjustments recommended by commenters, we made no adjustments to either the adjusted standardized amounts or to the budget neutrality estimates for conditions that could not be quantified on the basis of currently available data, even if there were a likelihood that these conditions might exist under prospective payment. For example, no adjustment was made for the likelihood that admissions would increase more rapidly under prospective payment than under the provisions of Pub. L. 97-248, or for costs that might be disallowed as a result of audit or desk review by the intermediaries. *Likewise, we made no attempt to quantify adjustments* ***for the likelihood of transfers*** *under prospective payment*, emergency room services, and disallowed costs which are successfully appealed.[39]

Accordingly, while the Providers did not appeal the budget neutrality adjustment, the above excerpt suggests that the Providers' concern about the Secretary's alleged mistreatment of transfers may be misplaced and that the treatment of transfers in the in the context of the budget neutrality adjustment for FFY 1984 may have more significance.

Finally, the Secretary also declined to increase the base standardized amount to reflect the increased costs associated with the shift in costs of hospital-based physician services from Part B to Part A, as suggested in a comment. The Secretary noted that such an increase would simply be offset or neutralized by a corresponding increase in the budget neutrality adjustment for FFY 1984:

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[37] 48 Fed. Reg. 39752, 39840-41 (Sept. 1, 1983) (bold, underline emphases added, and italics emphasis in original).
[38] 49 Fed. Reg. 234, 334 (Jan. 3, 1984).
[39] *Id.* at 255 (Emphasis added.) *See also id.* at 331 (stating as part of the discussion on the budget neutrality adjustments: "The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) established a DRG-adjusted limit on the allowable amount of inpatient operating costs per case and a per case limit on the rate of increase of operating costs of inpatient hospital services. Due to these per case limits, the incentives that influence hospital admission patterns are similar under TEFRA and prospective payment. Accordingly, ***we have assumed that the number of admissions under both prior law and the prospective payment system will be the same***. As a result, the budget neutrality factors can be calculated by comparing reimbursement per discharge for each of the systems, and there is no need to estimate an actual number of hospital admissions." (emphasis added)).

> Finally, applying such an adjustment to the average standardized amounts (and, by extension, to the per case budget neutrality estimates of Federal rate payments) would not actually increase the level of payments under budget neutrality. If we were to increase the initial standardized amounts to reflect this shift, the budget neutrality adjustment factor would have to be recalculated, would accordingly be increased, and the net result would be virtually identical. As a result, such an adjustment would have no effect on payment levels during FYs 1984 and 1985, which are subject to budget neutrality.[40]

Regardless, the Secretary's application of a 0.970 budget neutrality adjustment factor to the FFY 1984 standardized amounts for the Federal rates confirms that these standardized rates were too high and were reduced by a factor of 0.030. Thus, the ***final*** IPPS payment rates as used for the first year of IPPS (*i.e.*, FFY 1984), as finalized on January 3, 1984, reflect the Secretary's FFY 1984 budget neutrality adjustment. Moreover, as previously noted, since the FFY 1984 budget neutrality adjustment is based on an ***external, fixed*** reference point (*i.e.*, no greater and no less than the reference point) and is not reviewable, the FFY 1984 budget neutrality adjustment effectively ***fixed*** the standardized amounts for FFY 1984 as used from that point forward (*i.e.*, as used both for the FFY 1984 IPPS payment rates and for subsequent years).

2. *The FFY 1985 budget neutrality adjustment also reduced the FFY 1985 standardized amounts, reaffirming that the Secretary's determined that the initial standardized amounts for FFY 1984 were set too high.*

For FFY 1985, the Secretary applied a budget neutrality adjustment of 0.954 to the standardized amounts used for the Federal national rates and 0.950 to the standardized amounts used for the regional rates. The Secretary described these adjustments as follows:

> In accordance with section 1886(e)(1) of the Act, the prospective payment system should result in aggregate program reimbursement equal to "what would have been payable" under the reasonable cost provisions of prior law; that is, for FYs 1984 and 1985, the prospective payment system must be "budget neutral".
>
> During the transition period, the prospective payment rates are a blend of a hospital-specific portion and a Federal portion. ***Further, effective October 1,1984***, *the Federal portion will be a blend of national and regional rates*. As a result, we must determine three budget neutrality adjustments— one each for both the national and regional rates, and one for the hospital-specific portions. The methodology we are using to make these adjustments is explained in detail in section V. of this addendum.

[40] *Id.* at 255.

> Based on the data available to date, we have computed the following Federal rate budget neutrality adjustment factors:
>
> Regional—.950
> National—.954[41]
>
> ****

By finalizing an adjustment factor less than 1, the Secretary confirmed that the standardized amounts were too high. Thus, like her budget neutrality adjustments made for FFY 1984, the Secretary again confirmed that the standardized amounts were too high and exercised her discretion to reduce the standardized amounts to be used in the ***final*** FFY 1985 IPPS rates.[42]

3. *The Secretary has applied the FFY 1985 budget neutrality-adjusted rates to FFY 1986 and subsequent years.*

For FFY 1986, the Secretary confirmed that she used the FFY 1985 budget neutrality adjusted federal rates as the basis for determining the FFY 1986 federal rates:

> [T]he FY 1985 adjusted average standardized amounts (Federal rates) were required by law to be adjusted to achieve budget neutrality; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be ***neither more nor less than*** *we estimated would have been paid under prior legislation for the costs of the same services*. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) ***These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years***.
>
> Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were higher than necessary to achieve budget neutrality. Therefore, we have updated the FY 1985 standardized amounts using a factor that takes into account the overstatement of the FY 1985 amounts ***to ensure that accuracy of the FY 1986***

[41] 49 Fed. Reg. 34728, 34769 (Aug. 31, 1984).

[42] In the preamble to the FFY 1985 Final Rule, the Secretary "noted that most of the data that the budget neutrality adjustment is based on has already been made available [to the public]. We believe that these data in conjunction with the explanation of the budget neutrality methodology presented in the NPRM (49 FR 27458) should enable individuals to replicate the adjustment factors. . . . In addition, we believe the lengthy and detailed description of the data and the development of rates contained in the **Federal Register**, along with the many examples furnished, afford the reader all the information necessary for an understanding of the prospective payment system. Those individuals, hospitals, or associations desiring additional data and other material, either for verification of rates or for other purposes, may request this date under the Freedom of Information Act." 49 Fed. Reg. at 34771.

> ***standardized amounts***. To this end, we have identified several factors, discussed in section III.A.3.c., below, that contributed to the *overstatement* of the FY 1985 standardized amounts. We have determined an appropriate percent value for each of them, and have combined them into a proposed composite ***correction*** factor for FY 1986 that equals —7.5 percent.[43]

Significantly, in the above excerpt, the Secretary further confirmed that "[t]hese budget neutrality-adjusted rates for FY 1985 are then to be used *as the basis for the determination of rates* ***for later years***."[44] While it is true that the implementation of these rates for FFY 1986 were delayed by Congressional action extending the FFY 1985 rates through April 30, 1986 (as discussed further in **Appendix B**), the Secretary confirmed that it used the rates published in the FFY 1986 IPPS Final Rule plus a 1.0 percent modification specified by Congress:

> Section 9101(a) of Pub. L. 99-272 amends section 5(c) of Pub. L. 99-107 to extend the FY 1985 inpatient hospital prospective payment rates through April 30,1986. Therefore, the DRG classification changes and recalibrated DRG weights that were set forth in the September 3,1985 final rule (50 FR 35722) are effective for discharges occurring on or after May 1, 1986.
>
> ****
>
> In accordance with the provisions of section 9101(b) and (e) of Pub. L. 99-272, the adjusted standardized amounts that were published in the September 3,1985 final rule (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986. The revised standardized amounts are set forth in Table 1, below.[45]

Significantly, *a glaring gap in the Providers' response to the Medicare Contractor's jurisdictional challenge* is their failure discuss or even recognize how the Secretary interpreted and applied the FFY 1985 budget neutrality adjustment.

The Board has set forth in **Appendix C** excerpts from the preambles of other final rules to provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates applied to later years. Thus, *regardless of how the Providers contend*

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[43] 50 Fed. Reg. 35646, 35695 (Sept. 3 1985) (emphasis added). *See also* 49 Fed. Reg. at 34767 (stating "We believe the explicit language of section 2310 of Pub. L. 98-369 and section 1886(d)(3)(A) of the Act requires a reduction in the standardized amounts used to compute the Federal rates before adjusting for budget neutrality. . .. Thus, while the Federal rates. . .. have been reduced in this final rule to reflect the inflation factor prescribed by section 2310 of Pub. L. 98-369, we point out that the offset for budget neutrality has also been adjusted. The reduction in the regional and national standardized rates . . . attributable to section 2310 of Pub. L. 98-369 is entirely due to the revised budget neutrality adjustments for 1984 and 1985.").

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

[45] 87 Fed. Reg. 16772, 16773 (May 6, 1986).

the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment, it is clear that:

1. The Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and

2. The FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

Accordingly, the Board finds that the Providers' issue is inextricably tied, at a minimum, to the FFY 1985 budget neutrality adjustments.

* * * * *

In summary, the Providers confirm they do not seek to challenge the FFY 1984 or 1985 IPPS payments or the associated FFY 1984 and 1985 budget neutrality adjustments, but rather, as the hospitals in *St. Francis*,[46] they challenge "their IPPS payments for the years under appeal as incorrectly understated because they were determined from errors in the application of 1981 cost-reporting data that was used to calculate the standardized amounts in 1983, which were then carried forward every year to the present."[47]

The Board disagrees and finds that it lacks substantive jurisdiction over the issue raised in these appeals because the *prospectively-set* standardized amounts used for IPPS rates for FFYs 1984 and FFY 1985 are each based on the budget neutrality adjustment made for that FFY and the 1984 and 1985 budget neutrality adjustments are presumably designed to be corrective of the initial base that was set *using 1981 data*.[48] Therefore, the *final* FFY 1984 and 1985 standardized amounts are *inextricably intertwined* with those applicable budget neutrality adjustments.[49] Indeed, the

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[46] *St. Francis Medical Center v. Azar*, No. 17-5098 (D.C. Cir., June 29, 2018).
[47] *E.g.*, PRRB Case Nos. 21-1497GC, Group Issue Statement.
[48] The Board has included at **Appendix B** examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments. These intervening adjustments for FFYs 1986 and 2018 include both mandatory and discretionary revisions ***to the standardized amounts*** (as well as the Congress' decisions to revise or not revise the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i)) and highlight the complexity of the issue before the Board, particularly where such adjustments were made in a budget neutral manner or were based on factoring in certain other estimated impacts
[49] *See DCH Reg'l Med. Ctr. v. Azar*, 925 F.3d 503, 507 (D.C. Cir. 2019) ("We cannot review the Secretary's method of estimation without also reviewing the estimate. And because the two are inextricably intertwined, section 1395ww(r)(3)(A) precludes review of both."); *Mercy Hosp., Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("As both a textual and a practical matter, the LIP adjustment is inextricably intertwined with the step-two rate, and so the shield that protects the step-two rate from review protects the LIP adjustment as well."); *Yale New Haven Hosp. v. Becerra*, 56 F.4th 9, 18 (2nd Cir. 2022) ("Thus, we join the D.C. Circuit in "reject[ing] the argument that 'an "estimate" is not the same thing as the "data" on which it is based.'" *DCH Reg'l Med. Ctr. v. Azar* . . . . We also adopt the D.C. Circuit's holding that "[i]n this statutory scheme, a challenge to the [Secretary's choice of what data to include and exclude] for estimating uncompensated care is ... a challenge to the estimates themselves. The statute draws no distinction between the two." *Id*. at 506. Indeed, the statutory text of section 1395ww(r)(2)(C)(i) explicitly and affirmatively defines the statutory term "estimate[ ]" to encompass "the Secretary['s] determin[ation]" of what data is

Secretary applied a budget neutrality adjustment to those years to reduce the standardized amounts by factors of approximately 0.03 for FFY 1984 and 0.05 for FFY 1985 and, thus, these budget neutrality adjustments appear to have already automatically accounted for any such alleged errors in setting the initial base rate (which again was based on *1981 data*).[50] Because the FFY 1985 budget neutrality-adjusted rate was used/flowed forward for determining FFY 1986 rates and the rates for subsequent FFYs and because 42 U.S.C. 1395ww(d)(7) prohibits administrative or judicial review of the FFY 1984 and 1985 budget neutrality adjustments and the resulting *final* standardized amount for FFY 1985 was carried/flowed forward to FFY 1986 and succeeding FFYs, the Board may not review the standardized amount used for the FFYs being appealed as it relates to the common issue in these appeals. In this regard, the Board again notes that the rates for FFY 1986 and subsequent years are based on the budget neutrality adjusted FFY 1985 rates and the Providers may not simply pass through, or over, the budget neutrality adjustments for FFYs 1984 and 1985, *for purpose of future FFYs*, because those adjustments are tied to an absolute *external* event (the Secretary's estimate, based on the best available data, of what would have been paid for those years if there were no IPPS) ***and*** were ***fixed*** (no greater *and* no less than what would have been paid had there been no IPPS). To do otherwise, would impact the very integrity of IPPS.

Accordingly, the Board finds that: (1) the appealed issue is *inextricably* intertwined with the FFY 1984 and 1985 budget neutrality adjustments to the standardized amounts *for purposes of future FFYs* under the operation of 42 U.S.C. §§ 1395ww(b)(3)(B), 1395ww(d)(3)(A), and both 1395ww(d)(2)(F) and 1395ww(d)(3)(C) which reference 1395ww(e)(1)(B), as demonstrated by the fact that the FFY 1985 budget-neutrality adjusted rates were used as the basis for the determination of rates for FFY 1986 and later years; and (2) 42 U.S.C. §§ 1395oo(g)(2) and 1395ww(d)(7) (and related implementing regulations[51]) prohibit administrative and judicial review of those budget neutrality adjustments. Based on these findings, the Board concludes that it does not have substantive jurisdiction over the issue in the three (3) CIRP group cases listed in

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the "be[st] proxy for the costs of [qualifying] hospitals for treating the uninsured" and, ultimately, of what data to "use" or not "use." 42 U.S.C. § 1395ww(r)(2)(C)(i)." (citations partially omitted)). Similarly, the Board notes that the Board erred in finding that it had jurisdiction in *Columbia/HCA 1984-1986 PPS Federal Rate/Malpractice Group v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2000-D74 (Aug. 18, 2000). In that decision, the Board found that "the issue in this case, whether the federal portion of the PPS rates should be adjusted because it was based on 1981 hospital cost report data which incorporated an invalid 1979 Malpractice Rule, does not fall into either [of the] limitations on Board jurisdiction [at 42 U.S.C. §§ 1395ww(d)(7) or 1395oo(g)(2)]. The Board finds that it can determine whether the existing statute and regulations concerning the establishment of the federal portion of the PPS rate require or permit retroactive adjustments." *Id.* at 16. The Board further found that "the retroactive adjustment proposed by the Provider would increase the federal portion of the PPS rates ***and therefore require some adjustment to be made to maintain budget neutrality***. 42 U.S.C. § 1395ww(e) and 42 C.F.R. § 412.63(j)" but that "[b]ecause the Board has determined that the adjustments are not required, how those adjustments would be made are moot, and in any event would not be subject to review by the Board. 42 C.F.R. § 405.1804(a)." *Id.* at 18 (Emphasis added.) While the Board's 2000 decision got it right that the FFY 1984 budget neutrality provision is implicated and precluded from administrative review, the above case law demonstrates that the Board erred in finding it could review the FY 1984 standardized amounts. Rather, the case law (as well as the Board's discussion herein) demonstrate that any adjustment to the FFY 1984 standardized amounts would be *inextricably* tied to the ensuing budget neutrality adjustments made for FFYs 1984 and 1985.

[50] *See supra* note 33 (discussing how the removal of nurse anesthetists costs were removed from IPPS and how that removal was *automatically* accounted for as part of the 1985 budget neutrality adjustment).

[51] *See, e.g.*, 42 C.F.R. §§ 405.1804, 405.1840(b)(2).

Appendix A, and hereby closes these three (3) group cases and removes them 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:

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Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA

For the Board:

3/8/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS
Jacqueline Vaughn, CMS OAA

APPENDIX A
Jurisdictional Challenge; Cases at Issue

On September 22, 2023, the Medicare Contractor filed a challenge to the following three (3) cases which share a common Medicare Contractor, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E):

21-1497GC	Kaiser Health CY 2019 Standardized Amount Base Rate Accuracy CIRP Group
22-0926GC	Kaiser Health CY 2018 Kaiser Health CY 2018 Standard. Amt Base Rate Accuracy CIRP Grp
22-0972GC	Kaiser Health CY 2020 Kaiser Health CY 2020 Standard. Amt Base Rate Accuracy CIRP Grp

APPENDIX B

The following are examples of other adjustments to the standardized amounts that have occurred outside of the FFY 1984 and 1985 budget neutrality adjustments and the "applicable percentage increases" for FFYs 1986 and forward as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i):

a. "Restandardization of base year costs per case used in [the] calculation of Federal rates" for both the labor and non-labor portions to reflect the survey-based wage index as discussed in the FY 1986 IPP Final Rule. 50 Fed. Reg. 35646, 35692 (Sept. 3, 1985).

b. Recalibration of DRG weights done in a budget neutral manner pursuant to 42 U.S.C. § 1395ww(d)(4)(C) at least every 4 years beginning with 1986.[52] An example of recalibration can be found in the FY 1986 IPPS Final Rule wherein the Secretary changed its methodology for calculating the DRG relative weights.[53]

c. Budget neutrality adjustments made to the standardized amount designated for urban hospitals and the one designated for rural hospitals when certain urban hospitals were

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[52] The Secretary confirmed that, beginning in 1991, these adjustments are to be made in a budget neutral manner:

> Section 1886(d)(4)(C)(iii) of the Act requires that beginning with FY 1991, reclassification and recalibration changes be made in a manner that assures that the aggregate payments are neither greater than nor less than the aggregate payments that would have been made without the changes. Although normalization is intended to achieve this effect, equating the average case weight after recalibration to the average case weight before recalibration does not necessarily achieve budget neutrality with respect to aggregate payments to hospitals because payment to hospitals is affected by factors other than average case weight. Therefore, as discussed in section II.A.4.b. of the Addendum to this final rule, we are making a budget neutrality adjustment to implement the requirement of section 1886(d)(4)(C)(iii) of the Act.

59 Fed. Reg. 45330, 45348 (Sept. 1, 1994).

[53] 50 Fed. Reg. 35646, 35652 (Sept. 3, 1985). As part of this recalibration process, the Secretary responded to a comment on the use of transfers in the recalibration process as follows:

> *Comment:* A commenter was concerned that, by including transfer cases in the calculation of the relative weights, we might be inappropriately reducing the relative weights of DRGs in which there are significant proportions of transfer cases.
>
> *Response:* This commenter assumes that the charges for transfer cases are lower than charges for the average case in a DRG. Our data show that this assumption is not correct for many DRGs. To test the effect of including transfers in the calculation of the relative weights, we computed mean charges for each DRG, both with and without the transfer cases. We then conducted statistical tests to determine whether these two means differed significantly at the .05 confidence level (that is, there is only a .05 probability that the observed difference in the means would occur if the two sets of cases came from the same underlying population). The results indicate that transfers have a statistically significant effect on the mean charges of only 16 DRGs. For 13 of the 16 DRGs, inclusion of transfer cases tends to ***increase*** the mean charges. However, for three DRGs, the mean charges are reduced by the inclusion of the transfer cases.
>
> Since the inclusion of transfer cases raises the mean charges for some DRGs and lowers them for others, and because these effects are limited to such a small number of DRGs, we decided not to revise the method we used to recalibrate the relative weights. During FY 1986, we will be studying the entire issue of transfers and the appropriate payment for these cases. This study may reveal other ways of handling transfer cases in future recalibrations.

Id. at 35655-56.

deemed to be urban effective with discharges occurring on or after October 1, 1988. 53 Fed. Reg. 38476, 38499-500, 38539 (Sept. 30, 1988) (implementing OBRA 87, Pub. L. 100-203, § 4005).[54]

d. Effective for FFY 1995, eliminating the initial two standardized amounts (one for urban hospital and another for rural hospitals)[55] and replacing them with one single standardized amount as specified at 42 C.F.R. § 1395ww(d)(3)(C)(iii).[56]

e. Budget neutrality provision at 42 U.S.C. § 1395ww(d)(3)(A)(vi) that allows Secretary to adjust standardized amount to eliminate the effect of "changes in coding or classification of discharges that do not reflect real changes in case mix."[57]

f. The discretion of the Secretary in 42 U.S.C. § 1395ww(d)(3)(I)(i) to "provide by regulation for such other exceptions and adjustments to such payments amounts under this subsection as the Secretary deems appropriate."

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[54] *See also* 56 Fed. Reg. 43358, 43373 (Aug. 30, 1991) (stating "Consistent with the prospective payment system for operating costs, the September 1, 1987 capital final rule provided for separate standardized amounts for hospitals located in urban and rural areas. Subsequently, the Omnibus Budget Reconciliation Act of 1987 (Pub. L. 100-203) provided for a higher update factor for hospitals located in large urban areas than in other urban areas and thereby established three standardized amounts under the prospective payment system for operating costs. Large urban areas are defined as those metropolitan statistical areas (MSAs) with a population of more than 1 million (or New England County metropolitan statistical areas (NECMAs) with a population of more than 970,000). Beginning with discharges on or after April 1,1988 and continuing to FY 1995, the Congress has also established higher update factors for rural hospitals than for urban hospitals. The differential updates have had the effect of substantially reducing the differential between the rural and other urban standardized amounts. Section 4002(c) of Public Law 101-508 provides for the elimination of the separate standardized amounts for rural and other urban hospitals in FY 1995 by equating the rural standardized amount to the other urban standardized amount. The separate standardized amount for large urban hospitals would continue. Currently, the large urban standardized amount under the prospective payment system for operating costs is 1.6 percent higher than the standardized amount for hospitals located in other urban areas.").

[55] *See* 42 U.S.C. §§ 1395ww(d)(2)(D), 1395ww(d)(3)(A); *supra* note 15.

[56] Omnibus Reconciliation Act of 1990, Pub. L. 101-508, § 4002(c), 104 Stat. 1388, 1388-33 – 1388-35 (1990).

[57] For example, the Secretary included the following discussion in the preamble to the FFY 1986 IPPS Final Rule:

> As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.
> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year). However, we now have data that indicate that case mix has increased an additional 2.6 percent. Hospitals have been realizing the benefit of that increase through increased payments. Our update factor will be adjusted so as to not pass through in the FY 1987 rates 2.0 percentage points of the increase in case mix. However, the 0.6 percentage points that we estimate to reflect a real increase in case mix will be added to the update factor for FY 1987.

51 Fed. Reg. 31505-06.

g. The subsequent amendments that Congress made in 1994[58] and 1997[59] to add subparagraphs (I) and (J) to 42 U.S.C. § 1395ww(d)(5) to recognize and incorporate the concept of transfers into IPPS *in a budget neutral manner*. The Secretary made adjustments to the standardized amounts in order to implement the permanent incorporation of transfers into IPPS.[60]

To illustrate the complex nature of these issues, the Board points to the Secretary's exercise of her discretion under 42 U.S.C. § 1395ww(d)(3)(I)(i) on making recommendations to Congress on whether to make adjustments to the "applicable percentage increases" or update factor for FFY 1986 as provided in 42 U.S.C. § 1395ww(b)(3)(B)(i). In the September 1985 Final Rule,[61] the Secretary asserted that the FFY 1985 Federal rates were "overstated" and cited to the GAO's 1985 report entitled "Report to the Congress of the United States: Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare Prospective Payment System Rates" and, pursuant to 42 U.S.C. § 1395ww(e)(4), made a recommendation to Congress that it not provide any increase to FFY 1985 standardized amounts but rather freeze the FFY 1986 amounts at the FFY 1985 levels (*i.e.*, recommended an update factor of 0 percent for FFY 1986).[62] The following excerpts from that rulemaking describe how the Secretary determined that the FFY 1985 standardized amounts were overstated when reviewing whether to recommend that Congress adjust the update factor for the FFY 1986 standardized amounts:

> Since the standardized amounts for FY 1985 are used as the basis for the determination of rates for later years, the level of the FY 1985 standardized amounts must be corrected for any experience that developed since they were published. *We believe that it is necessary, **each year**, to review the appropriateness of the level of the previous year's prospective payment rates for providing reasonable payment for inpatient hospital services furnished to beneficiaries*. Further, we think this review must include assessment of whether the previous year's prospective payment rates have established adequate incentives for the efficient and effective delivery of needed care.

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[58] Social Security Act Amendments of 1994, § 109, Pub. L. 103-432, 108 Stat. 4398, 4408 (1994) placed the then-existing language of 42 U.S.C. § 1395ww(d)(5)(I) into clause (i) and added the following clause (ii): "(ii) In making adjustments under clause (i) for transfer cases (as defined by the Secretary) in a fiscal year, the Secretary may make adjustments to each of the average standardized amounts determined under paragraph (3) to assure that the aggregate payments made under this subsection for such fiscal year are not greater than or lesser than those that would have otherwise been made in such fiscal year."

[59] Balanced Budget Act of 1997, Pub. L. 105-33, § 4407, 111 Stat. 251, 401 (1997), further revised 42 U.S.C. § 1395ww(d)(5)(I) and added § 1395ww(d)(5)(J).

[60] *See* 60 Fed. Reg. 45778, 45854 (Sept. 1, 1995) ("[W]e are revising our payment methodology for transfer cases, so that we will pay double the per diem amount for the first day of a transfer case, and the per diem amount for each day after the first, up to the full DRG amount. For the data that we analyzed, this would result in additional payments for transfer cases of $159 million. *To implement this change in a budget neutral manner*, we adjusted the standardized amounts by applying a budget neutrality adjustment of 0.997583 in the proposed rule.").

[61] 50 Fed. Reg. 35646, 35704 (Sept. 3, 1985).

[62] U.S. Gov't Accountability Office, GAO/HRD-85-74, Use of Unaudited Hospital Cost Data Resulted in Overstatement of Medicare's Prospective Payment System Rates (1985).

In addition to this general consideration, *the FY 1985 adjusted average standardized amounts* (***Federal rates***) *were required by law* ***to be adjusted to achieve budget neutrality***; that is, to ensure that aggregate payments for the operating costs of inpatient hospital services would be *neither more* ***nor*** *less than* we estimated would have been paid under prior legislation for the costs of the same services. (The technical explanation of how this adjustment was made was published in the August 31, 1984 final rule (49 FR 34791).) *These budget neutrality-adjusted rates for FY 1985 are then to be used as the basis for the determination of rates for later years*.

Our FY 1985 budget neutrality adjustment factors were based on data and assumptions that resulted in standardized amounts that were ***higher*** *than necessary to achieve budget neutrality*. Therefore, *we have updated the FY 1985 standardized amounts using a factor that takes into account the* ***overstatement*** *of the FY 1985 amounts to ensure that accuracy of the FY 1986 standardized amounts*. To this end, we have identified several factors, ***discussed in section II.A.3.c.***, below, that contributed to the overstatement of the FY 1985 standardized amounts. *We have determined an appropriate percent value for each of them, and have combined them into* ***a proposed composite correction factor*** *for FY 1986 that equals –7.5 percent*.

In addition, we have developed factors representing productivity, technological advances, and the elimination of ineffective practice patterns, which are necessary to ensure the cost-effective delivery of care. Each of these factors interacts with the others, to some extent, and has an impact on the quality of care. Making conservative assumptions, we have determined an appropriate percent value for each of these factors, taking into consideration their potential effect on quality. **We have combined these values into a composite policy target adjustment factor**, **as discussed in section III.3.e., below**. For FY 1986, this factor equals —1.5 percent.

The Secretary is required under section 1886(e)(4) of the Act to make those adjustments in establishing the update factor that are ". . . necessary for the efficient and effective delivery of medically appropriate and necessary care of high quality." *Establishing FY 1986 prospective payment rates based on FY 1985 rates* ***that have been demonstrated to be overstated****, clearly would not comport with the statutory requirement that the rates represent payment for efficiently delivered care*.

Since the forecasted hospital market basket increase for FY 1986 is +4.27 percent, and the adjustment for Part B costs and FICA taxes

is +.31 percent, it is clear that there is a potential justification of a –4.42 percent decrease in the FY 1986 standardized amounts as compared to those for FY 1985 as described below:

	Percent
Forecasted market basket increase..	+4.27
Part B costs and FICA taxes.....	+.31
Composite correction factor.....	–7.5
Composite policy target adjustment factor.....	–1.5

However, for the reasons discussed in section II.A.3.f., below, we have decided that such a decrease is undesirable. Therefore, we are maintaining the FY 1986 standardized amounts at the same average level as FY 1985, in effect applying a zero percent update factor.[63]

****

(3) *Additional causes for the overstatement of FY 1985 Federal rates.* In addition to the factors above, which we believe we must correct, **other considerations also contributed significantly to the overstatement of the FY 1985 standardized amounts**.

When we set the standardized amounts for FY 1985, we made assumptions on hospital cost per case increases in order to estimate, for purposes of budget neutrality, the payments that would have been made had prior payment rules continued in effect. These assumed rates of increase in cost per case were 10.9 percent for 1983, 9.8 percent for 1984, and 9.8 percent for 1985. These assumptions were significantly higher than the actuarial estimates. The actuarially estimated rates of increase in cost per case (which ignore any effects of the prospective payment system such as shorter lengths of stay) are 9.8 percent for 1983, 8.1 percent for 1984, and 8.5 percent for 1985. After application of the revised market basket, discussed previously, use of these actuarial estimates would reduce the standardized amounts by an additional 1.2 percent.

For FY 1985, we also used 1981 unaudited, as-submitted cost reports (to get recent data as quickly as possible) to set the Federal rates. The hospital specific rates were set using later (1982 or 1983) cost reports that were fully audited. The audits adjusted the total cost for these reports downward by $2.2 billion, of which Medicare realized about $900 million in inpatient recoveries. **Since the cost data used to set the Federal rates do not reflect audit**

[63] 50 Fed. Reg. at 35695 (bold, italics, and underline emphasis added).

recoveries, it is likely that they are overstated by a similar amount. We do not know precisely what proportion of this amount applies to capital-related costs and other costs that would not affect the Federal rates. However, approximately 90 percent of hospitals" total inpatient costs are operating costs, and if only 40 percent of the $900 million in audit recoveries is related to Federal payments for inpatient operating costs, there would have been, conservatively estimated, at least a one percent overstatement of allowable costs incorporated into the cost data to determine the FY 1985 standardized amounts.

In addition, the General Accounting Office (GAO) recently conducted a study to evaluate the adequacy of the Standardized amounts. In its report to Congress dated July 18, 1985 (GAO/HRD-85-74), **GAO reported findings that the standardized amounts, as originally calculated, are overstated by as much as 4.3 percent because they were based on unaudited cost data and include elements of capital costs.** GAO recommended that the rates be adjusted accordingly.

We believe that these causes for the overstatement of the standardized amounts are related to our own procedures and decisions. Thus, they are unlike both the market basket index, which is a technical measure of input prices, and the increases in case-mix, which would not have been passed through beyond the extent to which they affected the estimates of cost per case. Further, as discussed below, even without making these corrections, we could justify a negative update factor for FY 1986, although we are not establishing one. **Since we have decided to set FY 1986 standardized amounts at the same level as those for FY 1985, making corrections now to reflect the cost per case assumptions and the audit data would have no practical effect. Therefore, we have decided <u>at this time not</u> to correct the standardized amounts for these factors.**

We received no comments on this issue.

(4) ***Composite Correction Factor.*** We are adjusting the standardized amounts as follows to take into consideration the overstatement of the prior years, amounts:

	Percent
Case mix.....	–6.3
Market basket.....	–1.2
Composite correction factor.....	–7.5[64]

[64] *Id.* at 35703-04 (bold and underline emphasis added).

Congress did immediately act on the Secretary's September 3, 1985 recommendation because, shortly thereafter on September 30, 1985, it enacted § 5(a) of the Emergency Extension Act of 1985 ("EEA-85") to maintain existing IPPS payment rates for FFY 1986 at the FFY 1985 Rates (*i.e.*, provide a 0 percent update factor) until November 14, 1985 as specified in EEA-85 § 5(c).[65] Congress subsequently modified this freeze on several different occasions as explained in the interim final rule published on May 6, 1986:

> - Pub. L. 99-155, enacted December 14, 1985, extended the [EEA-85] delay through December 14, 1985.
>
> - Pub. L. 99-181, enacted December 13, 1985, extended the [EEA-85] delay through December 18, 1985.
>
> - Pub. L. 99-189, enacted December 18, 1985, extended the [EEA-85] delay through December 19, 1985.
>
> - Pub. L. 99-201 enacted December 23, 1985, extended the [EEA-85] delay through March 14, 1986.[66]

Second, on April 7, 1986, Congress further revised EEA-85 § 5(c) by extending the 0 percent update factor through April 30, 1986 and then specified that, for discharges on or after May 1, 1986, the update factor would be ½ of a percentage point.[67] As previously discussed above in the decision at Section B.3, in the final rule published on May 6, 1986, the Secretary confirmed that "*the adjusted standardized amounts that were published in the September 3,1985 final rule* (which reflected a zero percent update) are updated by one-half of one percent effective for discharges on or after May 1,1986"[68] and these FFY 1986 adjusted standardized rates are based on the FFY 1985 budget neutrality-adjusted rates.

The examples highlight concerns about how certain future actions and decisions by the Secretary and Congress build upon prior decisions. Here, the Secretary's recommendation to Congress regard the FFY 1986 update factor were based on its analysis of the FFY 1984 and 1985 standardized amounts that had already been adjusted for budget neutrality. To the extent the 1984 standardized amounts had been *further* adjusted (*as* ***now*** *proposed by the Providers*), it could have potentially impacted the Secretary's recommendation to Congress for the FFY 1986 update factor as well as Congress' subsequent revisions to the updated factor. Accordingly, this highlights how revisiting and otherwise adjusting the FY 1984 standardized amounts can have ripple effects with the update factor and other adjustments that were made for subsequent years *based on analysis of the prior year(s) and other information*.

---

[65] Pub. L. 99-107, § 5(a), 99 Stat. 479, 479 (1985). In July 1984, Congress had *already* reduced the 1 percent update factor planned for FFY 1986 to ¼ of a percentage point. Deficit Reduction Act of 1984, Pub. L. 98-369, § 2310(a), 98 Stat. 494, 1075 (1984). As part of the Emergency Extension Act of 1985, Congress further reduced the update factor for FFY 1986, presumably in response to the Secretary's recommendation.
[66] 51 Fed. Reg. 16772, 16772 (May 6, 1986).
[67] *See id.* at 16773. *See also* Medicare and Medicaid Budget Reconciliation Amendments of 1985, Pub. L. 99-272, § 9101(a), 100 Stat. 151, 153 (1986).
[68] 51 Fed. Reg. at 16773.

APPENDIX C

In its decision, the Board has noted that the Secretary confirmed in the preamble of the FFY 1986 IPPS Final Rule that the FFY budget neutrality-adjusted rates were used in determining the rates for FFY 1986 and would similarly be part of subsequent FFYs rates. The following excerpts from the preambles to IPPS final rules provide additional contexts in which the Secretary confirmed that the FFY 1985 budget neutrality-adjusted rates were part of the rate for later FFYs and illustrate how embedded the FFY 1985 budget neutrality-adjusted rates are in the rates used for FFY 1986 and subsequent years. Thus, *regardless of how the Providers contend the Medicare statute should be interpreted relative to the 1985 budget neutrality adjustment*, it is clear that the Secretary herself interpreted those provisions as requiring the application of the FFY 1985 budget neutrality-adjusted rates to later years; and that the FFY 1985 budget neutrality-adjusted rates are the basis for the rates used in FFY 1986 forward through to the years at issue.

1. In the preamble to the FFY 1986 IPPS Final Rule, the Secretary recognizes that the FFY 1985 budget neutrality adjustment accounted for the removal of nonphysician anesthetist costs from the base rates and no further adjustments were needed relative to those costs since the FFY 1985 budget neutrality-adjusted rates were used in determining the FY 1986 rates and would similarly be used for the 1987 rates:

> c. *Nonphysician anesthetist costs*. In the August 31, 1984 final rule, we implemented section 2312 of Pub. L. 98-369, which provided that hospital costs for the services of nonphysician anesthetists will be paid in full as a reasonable cost pass-through for cost reporting periods beginning before October 1, 1987. We did not directly reduce the FY 1985 Federal rates to exclude the estimated costs of these services, **because any required adjustment would be incorporated in the budget neutrality adjustment factors applied to the national and regional standardized amounts.** (See 49 FR 34794; August 31, 1984). **Since the FY 1986 standardized amounts are derived from an update of the FY 1985 amounts, which were adjusted for budget neutrality, the rates will automatically include the appropriate adjustment**. We are not making further adjustments to the Federal rates for this factor for either FY 1986 or FY 1987.[69]

[69] 50 Fed. Reg. at 35708 (Italics emphasis in original and bold and underline emphasis added). In this regard, the Board notes that the FFY 1985 IPPS Final Rule explained how the FFY 1985 budget neutrality adjustment accounted for Anesthetists services:

> *Anesthetists' Services*. Under section 2312 of Pub. L. 98-369, the costs to the hospital of the services of nonphysician anesthetists will be reimbursed in full by Medicare on a reasonable cost basis. In order to ensure that these services will be paid for only once, we must remove their costs from the prospective payment rates.

2. In the preamble to the FFY 1987 IPPS Final Rule, the Secretary explains how her budget neutrality adjustments for FFYs 1984 and 1985 had "already built case-mix increases into the cost-per case assumptions used in deriving the budget neutral prospective rates for FY 1984 and FY 1985" and confirms that "FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year)":

> *Comment*: Several commenters stated that we did not consider real case mix increases in the 1983 to 1984 period, and that we finally are considering real case mix increases for the first time.
>
> *Response*: FY 1984 and FY 1985 were years subject to the requirements for budget neutrality. As required under section 1886(e)(1) of the Act, payments under the prospective payment system were to be equal to what would have been paid under rate-of-increase and peer group limits on reasonable costs under prior law (section 1886(b) of the Act) as if the prospective payment system had never been implemented. Under the rate-of-increase limits and peer group limits, as long as a hospital's cost was lower than that hospital's limits, we paid that cost, regardless of whether real case mix increased or decreased, and regardless of the effect of actual case mix on the cost level for that hospital. . . . Increases in real case mix were built into the cost per case increase assumptions we used to model the rate-of-increase limits. These assumptions took into account estimates of the impact of the rate-of-increase limits and the peer group limits. **Consequently, we considered increases in real case mix in FYs 1984 and 1985.** Moreover, even these assumed increases in cost per case proved to be overstated as we received more recent data against which to evaluate our estimates. To have passed through updated prospective payment case-mix increases for FY 1984 and FY 1985 would have been improper because they would increase program payments over the level that would have been paid under the section 1886(b) limits. **As stated above, we have already built case-mix increases into the cost-per-case assumptions used in deriving budget neutral prospective payment rates for FY 1984 and FY 1985.**

For cost reporting periods beginning in FY 1985, we have reduced the adjusted standardized amounts to reflect the removal of these costs **by means of the budget neutrality adjustment methodology**. Our method for doing this is explained in section V.D. of this Addendum. We estimate that FY 1985 payments for anesthetists' services will be about $160 million, or 0.5 percent of Medicare operating costs for hospital accounting years beginning in FY 1985.

> Now that there is no further requirement for budget neutrality, we agree that real case-mix increases should be explicitly recognized. In fact, to the extent that case mix continues to increase, hospitals realize the benefit of such increase in increased payments for the current year. This is because we do not recoup payments already made, but only adjust the rates to avoid compounding such overpayments in the future. **Thus, FY 1986 prospective payment rates were based on FY 1985 rates, corrected to eliminate all increases in case mix through FY 1985 (since FY 1985 was a budget neutral year).**

3. In the preamble to the FFY 1988 IPPS Final Rule, the Secretary again recognizes the prior FFY 1985 budget neutrality adjustments to the standardized amounts had already taken into account the removal of nonphysician anesthetist costs and the *FFY 1985 budget neutrality-adjusted rates* ***were reflected in the FFY 1986, 1987, and 1988 rates.***

> c. *Nonphysician Anesthetist Costs*. Section 1886(d)(5)(E) of the Act provides that hospital costs for the services of nonphysician anesthetists are paid in full as a reasonable cost pass-through. Under section 2312(c) of Pub. L. 98-369, this pass-through was made effective for cost reporting periods beginning on or after October 1,1984, and before October 1,1987. Section 9320(a) of Pub. L. 99-509 extended the period of applicability of this pass-through so that services will continue to be paid under reasonable cost for any cost reporting periods (or parts of cost reporting periods) ending before January 1,1989 and struck subsection (E) effective on that date.
>
> In the September 3, 1985 final rule, we noted that to the extent an adjustment was warranted to reflect the removal of these costs from the prospective payment rates for FY 1985, it was incorporated in the overall **budget neutrality** adjustment (50 FR 35708). Therefore, **because this adjustment has already been built into the FY 1985 base from which the FY 1986, FY 1987, and proposed FY 1988 rates are derived**, we did not propose to make further adjustments to the average standardized amounts for FY 1988.[70]

[70] 52 Fed. Reg. 33034, 33064 (Sept. 1, 1987) (emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Notice of Dismissal***
Largo Medical Center, Prov. No. 10-0248, FYE 02/29/2012
Case No. 17-0417

Dear Ms. Banks and Mr. Berends,

The Provider Reimbursement Review Board ("Board or PRRB") is in receipt of the Medicare Contractor's September 15, 2017 Jurisdictional Challenge and the Provider's October 13, 2017 Jurisdictional Response. The Board's decision is set forth below.

Background

Largo Medical Center ("Largo"), Provider No. 10-0248, FYE 2/29/12, timely filed an Individual Appeal Request on November 8, 2016, from a Notice of Program Reimbursement ("NPR") dated May 12, 2016, challenging its direct graduate medical education ("DGME") and indirect medical education ("IME") full time equivalent ("FTE") resident caps.

On September 15, 2017, the Medicare Contractor filed a Jurisdictional Challenge contesting the Provider's total amount in controversy. The Medicare Contractor asserts the total amount in controversy, as it applies to the subject cost reporting period, has no reimbursement impact. Therefore, the Board does not have jurisdiction over the issue in this appeal.[1] The Medicare Contractor contends the Provider has not demonstrated the amount in controversy meets the qualifying threshold of $10,000 for a PRRB appeal. To the contrary, the Provider has disclosed the stated impact of $10,000 is associated with projected future period impacts, through footnote 1 of the Appeal Request on Form A and footnote 1 of Form C. The Medicare Contractor asserts both footnotes are identical and state:

> This appeal relates to the setting of Medicare direct and indirect graduate medical education (GME) caps at Largo Medical Center. EYE 2/29/12 is the fourth year the hospital trained residents and is, therefore, the first year to which direct and indirect GME caps apply to reimbursement calculations for residency training. Because Largo trained fewer resident FTEs in the fiscal year at issue than its adjusted caps, the Provider acknowledges that there is no amount in controversy for the fiscal year at issue in this appeal. Nonetheless, the Provider is filing this appeal consistent with the 42 C.F R § 405 1885

[1] Provider's September 15, 2017 Jurisdictional Challenge at 2.

> requirement that predicate facts be timely appealed in the fiscal period in which the predicate fact first arose or the fiscal period for which such fact was first determined by the intermediary. In the *Federal Register* preamble discussion of the predicate fact rule, commenters raised the issue of situations in which "the first application of the predicate fact results in a reimbursement impact that is less than the jurisdictional amount for appeal to the Board." See 78 Fed. Reg 74826, 75167-68 (Dec. 10, 2013). CMS's response to this issue (recommending that the provide appeal to the intermediary hearing officers if the amount in controversy is at least $1,000) does not address the issue at hand, given that WPS's GME cap calculations had no financial effect on the provider in the current year. The Provider estimates that the financial impact of these adjustments most certainly exceeds $10,000 in FYE 2/28/2013 and will total much larger amounts in subsequent years. The Provider intends to appeal the same adjustments in all subsequent years as NPRs are issued.

The Medicare Contractor contends the Provider does not deny the impact is below even the intermediary level of $1,000. Thus, this appeal does not meet jurisdictional requirements of either venue. Also, the amount in controversy does not meet the established threshold for a PRRB appeal. The Medicare Contractor asserts the Provider readily admits to this fact. Thus, the Board should dismiss this case.[2]

On October 13, 2017, Largo filed a response to the Medicare Contractor's Jurisdictional Challenge. Largo acknowledges that the instant appeal does not satisfy the minimum amount in controversy for the fiscal year at issue. Largo maintains it filed the instant appeal consistent with the so-called "predicate facts' rule" promulgated by CMS in the calendar year 2014 Hospital Outpatient Prospective Payment System Final Rule at 78 Fed. Reg. 74826, 75162-69 (Dec. 10, 2013). Largo asserts in this rulemaking, CMS revised its cost report reopening regulation at 42 C.F.R. § 405.1885(a)(1) and (b)(2)(iv) to prohibit reopenings of subsequent cost report determinations that involve predicate facts determined in a prior cost reporting period, unless such predicate facts were timely appealed and/or addressed through reopening within the applicable 3 year reopening window for the cost reporting period in which the predicate facts first arose or were first established.[3]

Largo contends its newly established GME FTE caps, and the underlying data used to calculate them, constitute such "predicate facts," which will be used to determine its Medicare reimbursement in future cost reporting periods. Largo maintains accordingly, it filed the instant appeal in order to preserve its rights to challenge such predicate facts with respect to future cost reporting periods, in which the MAC's FTE cap-setting errors (i.e., the errors committed in this appealed NPR for the 2012 cost reporting period) will result in significant negative reimbursement impact to it, which is expected to exceed $100,000 annually. Largo asserts to the extent that CMS's "predicate facts" discussion . . . could be interpreted to require it to timely appeal the MAC's

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[2] *Id*. at 3.
[3] Medicare Contractor's October 13, 2017 Jurisdictional Challenge at 1-2.

erroneous calculation of its FTE caps for the first fiscal year in which the caps were established and applied, it filed this appeal, in an abundance of caution-notwithstanding the failure to meet the $10,000 minimum amount in controversy requirement with respect to the 2012 fiscal year under appeal in order to preserve its rights to challenge and correct the FTE caps with respect to future years.[4]

Decision of the Board:

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, and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

In the instant case, Largo *admits* that its appeal does not satisfy the $10,000 amount in controversy requirement for the fiscal year at issue. However, Largo maintains it filed the instant appeal consistent with the predicate facts rule. In this regard, its newly-established GME FTE caps, and the underlying data used to calculate them, constitute such "predicate facts," which will be used to determine its Medicare reimbursement in future cost reporting periods. Accordingly, Largo asserts that it filed the instant appeal *to preserve its rights* to challenge such predicate facts ***with respect to future cost reporting periods***, in which the MAC's FTE cap-setting errors will result in significant negative reimbursement impact to it. In other words, out of an abundance of caution, Largo filed this appeal to protects its appeal rights relative to future years., notwithstanding the failure to meet the $10,000 minimum amount in controversy requirement with respect to the 2012 fiscal year under appeal.

The Board finds that for a provider to have a right to a hearing before the Board, the statute at 42 U.S.C. § 1395oo(a) and the regulation at 42 C.F.R. §§ 405.1835(a)(2), requires that the minimum amount in controversy be $10,000. The Board finds in this case, Largo admits that it does not meet the $10,000 minimum requirement for a hearing before the Board. Largo does not meet the $10,000 amount in controversy. As such, the Board finds that it lacks jurisdiction over the Provider's appeal. The Board recognizes that the Provider filed this case to protect its appeal rights on the predicate fact and understands why the Provider took this protective step in light of the Agency's historical position on predicate facts as reflected at 42 C.F.R. § 405.1885. However, that regulatory provision is not applicable to appeals as made clear the U.S. Court of Appeals for D.C. Circuit in its 2018 decision *Saint Francis Med. Ctr. v. Azar*.[5] As a result, the Board finds the Provider's appeal rights of the predicate fact at issue are not affected because the Provider can appeal (and has appealed) the predicate fact at issue in its appeals of FYs 2013 through 2018. As the Provider failed to meet the minimum amount in controversy requirement of $10,000 and no amount in controversy exists for FY 2012, the Board dismisses the FY 2012

[4] *Id*. at 2.

[5] In support the Board points to the following decision of the U.S. Court of Appeals for the D.C. Circuit issued in 2018 which significantly was ***after*** *the Provider filed its appeal*: *Saint Francis Med. Ctr. v. Azar*, 894 F.3d 290 (D.C. Cir. 2018) ("hold[ing] that 42 C.F.R. § 405.1885 [as it relates to predicate facts] does ***not*** apply to appeals from a fiscal intermediary to the PRRB" and that "Just as the regulations governing reopenings do not extend to appeals, the statutes and regulations governing appeals do not incorporate the rules for reopenings").

appeal under Case No. 17-0417. As such, the Board closes Case No. 17-0417 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/11/2024

X Clayton J. Nix

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

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

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Via Electronic Delivery

Nicholas Putnam
Strategic Reimbursement Group, LLC
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Elmhurst, IL 60126

RE: ***Board Determination Regarding Deficient CIRP Group***

SRG Aurora 2014 DPP Medicare Part C Days CIRP Group – Case Number 18-0279GC
SRG Aurora 2014 Unmatched Medicaid Days CIRP Group – Case Number 18-0280GC

Dear Mr. Putnam:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeals in response to the Medicare Contractor's February 7, 2024 Motions to Dismiss. The Board notes that both groups were filed prior to the implementation of the Office of Hearing Case & Document Management System ("OH CDMS").[1] However, on October 28, 2021, the Parties in both groups were advised that the electronic record for the CIRP groups, which are considered "Legacy" cases, had been populated. Below is a discussion of the background and pertinent facts, the Regulations and Board Rules related to the specific deficiencies in this case, and the Board's determination.

Background:

On **November 1, 2021**, the Board issued revised Rules which changed certain procedures for group appeals. Specifically, Rule 20 addresses the population of Issues/Providers in the Office of Hearings Case & Document Management System ("OH CDMS"). Rule 20 advises that, "***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation."[2]

On **November 7, 2022**, the Board issued Alert 23, which gave notice that effective December 7, 2022, the Board was resuming its normal operations following the COVID- 19 Pandemic. The Alert 23 included a reminder to the Parties regarding the Rule 20 Certification requirement.

[1] Case Nos. 18-0279GC and 18-0280GC were filed on November 24, 2017.
[2] Emphasis added.

Pertinent Facts:

On **October 4, 2023**, Strategic Reimbursement Group, LLC ("Strategic"/"Group Representative") designated the subject CIRP groups to be fully formed. A Rule 20 Certification or a PDF Schedule of Providers with support pursuant to Board Rule 20.1 was due 60 days later. Because the deadline fell on Sunday, December 3, 2023, the due date rolled over to the following business day, Monday, December 4, 2023.

On **October 12, 2023**, the Board issued Group Completion and Critical Due Dates notifications for the subject group case, setting new deadlines for the appeal. The Groups' preliminary position paper deadlines were set for December 11, 2023.

On **December 5, and November 27, 2023**, respectively, Strategic timely filed the preliminary position papers in Case Nos. 18-0279GC and 18-0280GC.

On **February 7, 2024**, the Medicare Contractor filed Motions to Dismiss in each group. In its Motions, the Medicare Contractor advised that Strategic failed to comply with Board Rule 20/20.1. The Medicare Contractor indicated that, on January 3, 2024, it had conferred with Strategic via email about the Rule 20 letter in both groups.

Nevertheless, Strategic failed to timely respond to the Motion or file a Rule 20 Certification or SoP in either Case No. 18-0279GC or 18-0280GC.

Under Board Rule 44.3, Strategic had 30 days to respond to the Motion to Dismiss (i.e., until Friday, March 8, 2024). However, Strategic failed to timely respond to the Motion to Dismiss and, similarly, to date, has failed file a Rule 20 Certification or a PDF Schedule of Providers with support, as relevant.

Discussion of Regulations, Rules and Specific Deficiencies:

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

Further 42 C.F.R. § 405.1868 states that:

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. *The Board's powers include the authority to take appropriate actions in response to the* ***failure of a party*** *to a Board appeal* ***to comply***

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

The Board recognizes that its Critical Due Dates notifications do not include a deadline for filing, as relevant, the Rule 20 Certification or the traditional SoP under Board Rule 20.1. However, making the applicable filing under Board Rules 20 and 20.1 *is* ***and*** *remains* a requirement under Board Rules and must be done ***within 60 days of full formation,*** or in this case, should have been made when the Medicare Contractor brought it to the Representative's attention.

The Board is also cognizant of the fact that, on numerous occasions, it has explained the background and requirements of Board Rule 20 and Rule 20.1. Many times, as a courtesy, the Board has extended Strategic additional time to correct such deficiencies, however Strategic continues to miss or make deficient filings related to this Board Rule.[4]

Board Determination:

In Case Nos. 18-0279GC and 18-0280GC, the Board notes that the Rule 20 Certifications were due more than two months ago. Although the Medicare Contractor made Strategic aware of the Rule 20/20.1 deficiency in both groups via email and by filing Motions to Dismiss, to date Strategic has not filed the required documentation.

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[3] Emphasis added.

[4] The Board takes administrative notice of the following, non-exhaustive, examples of SRG-represented CIRP group cases in which the Board dismissed the Medicare Contractor's Motions to Dismiss as a Courtesy to SRG/the Participants (Case Nos. 14-1402GC, 15-0255GC, 23-0704GC, and 23-0739GC). Further, the Board identifies the following, non-exhaustive, examples of SRG-represented CIRP group cases in which the Board issued a Request for Information, giving SRG/the Participants 15 days to come into compliance with Rule 20/20.1 (Case Nos. 14-4233GC and 16-2016GC). Finally, the Board also notes the following, non-exhaustive, examples of SRG-represented CIRP group cases in which the Board dismissed the cases (Case Nos. 13-3937GC and 15-0244GC – no Rule 20/20.1 submission and failure to respond to the Board's scheduling order; Case No. 17-1299GC – late response to Board's scheduling order and late Rule 20/20.1 submission; Case Nos. 17-1304GC, 17-1305GC, 18-0278GC, and 18-0281GC – responded to Board's scheduling order but failed to file Rule 20/20.1 submissions; Case Nos. 15-0256GC and 17-0817GC – erroneous Rule 20 Certification and failure to respond to Board's scheduling orders). It is clear that SRG has had sufficient notification of what is expected, and how it is expected, yet continues to fail to meet the Board's requirements.

Rather than issuing a Scheduling Order requiring Strategic to file its Rule 20 Certification by a new date, as well as order it to respond to the Medicare Contractor's Motions as it has done in the past, the Board is electing to render its determination based on the current information in the records. In that regard, the Board finds that Strategic has ***again*** failed to file the required Rule 20 Certifications in the subject group appeals.

The Board is perplexed that, after the numerous notifications in which the Board has provided guidance and instruction to Strategic regarding Rule 20 requirements and submissions, as well as the many times it has extended the deadlines as a courtesy, Strategic continues to miss this critical deadline.[5] Indeed, the Board has warned that failure to come into compliance with Board Rule 20 and 20.1 may result in the Board taking remedial action such as dismissal.

Accordingly, it is also puzzling that Strategic tends to file its preliminary position papers by the Board deadlines (in these cases, in November and December, 2023), but still misses the deadlines for filing the Rule 20 Certifications (or PDF SoPs with support, as required under Rule 20.1) which are due around the same time. Similarly, it is confounding that Strategic did not respond to the Medicare Contractor's Motion to Dismiss. Because Strategic has again failed to timely file its Rule 20 Certifications and has failed to come into compliance with Rule 20/20.1 (even after the Medicare Contractor filed a Motion to Dismiss), the Board finds it appropriate to take remedial action and dismiss Case Nos. 18-0279GC and 18-0280GC, pursuant to its authority under 42 C.F.R. § 405.1868.

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

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

For the Board:

3/11/2024

X Kevin D. Smith, CPA

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

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

[5] *See supra* note 4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich
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1700 Pennsylvania Avenue, NW, Suite 900
Washington, DC 20006

RE: ***Board Determination on Optional Group with Single Provider***
King & Spalding CY 2009 SSI Ratio Data Match Group, Case No. 23-1318G
As it relates to the participants:
Lakeland Reg'l Health (Prov. No. 10-0157) FYE 9/30/2009, Case No. 14-2644
MUSC Medical Center (Prov. No. 42-004) FYE 6/30/2009, Case No. 17-2312

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("the Board") has reviewed the subject *optional* group appeal pursuant to a December 22, 2023 Jurisdictional Determination related to one of the two providers that formed the group. The pertinent facts and the Board's determination are set forth below.

Pertinent Facts:

On April 17, 2023, King & Spalding, LLP ("K&S") filed group appeal request to establish the optional group for the SSI Ratio Data Match issue for calendar year ("CY") 2009 under Case No. 23-1318G. On the same date of the group formation, K&S transferred the DSH SSI Percentage issue for the following providers:

- Lakeland Reg'l Health ("Lakeland") from its individual appeal, Case No. 14-2644; and
- MUSC Medical Center ("MUSC") from its individual appeal, Case No. 17-2312.

Case No. 17-2312 – MUSC:,

On September 27, 2017 MUSC filed an individual appeal for its FYE 6/30/2009 under Case No. 17-2312. The appeal included 5 issues, one of which included the DSH SSI Percentage.[1]

In June and September 2018, the Parties exchanged preliminary position papers.

On December 2, 2022, K&S filed the final position paper for Case No. 17-2312.

[1] On June 9, 2022 K & S became the authorized representative for Case No. 17-2312.

On December 29, 2022, the Medicare Contractor filed its final position paper.

On January 10, 2023, the Medicare Contractor filed a Jurisdictional Challenge over the SSI Data Matching issue (which it referred to as "DSH – SSI Systemic Errors") arguing that MUSC failed to file a complete Preliminary Position Paper with supporting documentation as required by the Board Rules.

On February 9, 2023, K & S responded to the Medicare Contractor's jurisdictional challenge.

On December 22, 2023, the Board issued a determination in which it found that MUSC failed to comply with the rules related to position papers regarding those claims for which evidence existed but had not been submitted. Specifically, the Board found that MUSC had not submitted any evidence of Part A and SSI eligible days it had identified through its own analysis, nor had it obtained or analyzed relevant South Carolina State Medicaid data which would support its claims. Consequently, the Board found that the Provider's position papers were not filed in compliance with Board Rule 25.2.A (2015) and Board Rule 25.2.2 (2018). Although the Board declined to dismiss the SSI Data Match issue in its entirety (due to the multifaceted nature of the arguments presented, and the fact that some arguments are purely legal in nature and may be viable without the evidence that was not submitted) from MUSC's individual appeal, the Board did *DENY* ***the request to transfer the SSI Data match issue to Case No. 23-1318G.***

The December 22, 2023 Transfer Denial for MUSC left only Lakeland as a participant in the optional group, Case No. 23-1318G.

Board Determination:

42 C.F.R. § 405.1837(b) specifies that 2 or more provider "may bring" (*i.e*., establish) an *optional* appeal:

> (2) *Optional group appeals*. (i) **Two or more** providers not under common ownership or control **may bring a group appeal** before the Board under this section, if the providers wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers. Alternatively, any provider may appeal to the Board any issues in a single provider appeal brought under §405.1835 of this subpart.[2]

[2] (Bold and underline emphasis added and italics emphasis in original.) This regulatory provision implements, in part, 42 U.S.C. § 1395oo(b) which pertains to "Appeals by Groups" and states: "The provisions of subsection (a) shall apply to any group of providers of services if each provider of services in such group would, upon the filing of an appeal (but without regard to the $10,000 limitation), be entitled to such a hearing, but only if the matters in controversy involve a common question of fact or interpretation of law or regulations and the amount in controversy is, in the aggregate, $50,000 or more."

Consistent with this regulation, Board Rule 12.6 provider the *minimum* number of providers in a group (CIRP and optional) and specifies that "[o]ptional group appeals must have *a minimum of **two** different providers . . . **at inception*** of the group."

Specifically, Board Rule 12.6 states:

> **12.6 Number of Providers in Group**
>
> This Rule is based on 42 C.F.R. § 405.1837(b)(3).
>
> ****
>
> **12.6.2 Optional Groups**
>
> Optional group appeals must have a minimum of two different providers, both at inception and at full formation of the group. The Board may limit the number of providers in an optional group appeal, or divide existing optional groups into various case numbers, as it deems necessary to ensure efficient case management. The Board may request the parties' input prior to limiting or dividing a case.

Accordingly, regarding the establishment of *optional* groups in the Office of Hearings Case & Document Management System ("OH CDMS"), the Commentary for Board Rule 12.1 confirms that the minimum of participants needed to establish a group (as specified in Board Rule 12.6 above) *must* be ***immediately*** added to the group:

> . . . if a group is to be formed solely through transfers, it may initially be established in OH CDMS with no participating providers. In such cases, the providers must be transferred ***immediately*** following the establishment of the group case in order to fulfill the regulatory requirement for the minimum number of providers per Rule 12.6. The Board will close all group cases that do not meet the minimum participant requirements.[3]

Here, although the optional group was initially formed in compliance with the above regulation and Board Rules, once the Board denied the transfer of MUSC to the group, it no longer met those requirements.[4] Accordingly, because the subject group appeal, under Case No. 23-1318G, is an *optional* group that now includes only a single provider and this fatal deficiency has not been ***immediately*** cured, the Board finds the *optional* group is not in compliance with the above Board Rules and regulation and, hereby, takes the following actions:

1. Disbands the *optional* group under Case No. 23-1318G;

[3] Board Rules v. 3.1 (Nov. 1, 2021) (underline emphasis added and bold and italics emphasis in original).
[4] K & S has not attempted to take any action to cure this deficiency in the 2 months since the second participant was dismissed from the optional group.

2. Reinstates the individual appeal under Case No. 14-2644[5] for the sole remaining participant, Lakeland Regional Medical Center (Prov. No. 10-0157);

3. Transfers the DSH SSI Fraction Days issue for Lakeland Regional Medical Center for CY 2009 back to the reinstated individual appeal under Case No. 14-2644 consistent with 42 C.F.R. § 405.1837(e)(5)(ii);[6] and

4. Closes Case No. 23-1318G as no participants remain.

Finally, the Board notes that the record in the Office of Hearings Case & Document Management System ("OH CDMS") for Case No. 14-2644 reflects that Lakeland and the MAC each filed their respective preliminary position papers but have not yet filed their final position papers. Accordingly, the Board will be issuing Notice of Hearing and Critical Due Dates, under separate cover, setting this case for hearing and setting deadlines for the final position papers.

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

For the Board:

3/11/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Geoff Pike, First Coast Service Options, Inc. (J-N) (MAC for 14-2644)

[5] Case No. 14-2644 was closed on 4/17/2023.
[6] 42 C.F.R. § 405.1837(e)(5)(ii) states: "When the Board determines that the requirements for a group appeal are not met (that is, when there has been a failure to meet the amount in controversy or the common issue requirement), it transfers the issue that was the subject of the group appeal to a single provider appeal (or appeals) for the provider (or providers) that meets (or meet) the requirements for a single provider appeal."

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Re: ***Dismissal for Failure to Meet Minimum Filing Requirements***
Castor Home Nursing FFY 2024 Notice of Quality Reporting Prog. Noncompliance Dec. Grp.
Case No. 24-1671G

Dear Mr. Sakthi and Ms. Huggins:

The Provider Reimbursement Review Board ("Board") is in receipt of the above-referenced *group* appeal request. After review of the facts outlined below, the Board has determined that the appeal request is fatally flawed as it was not filed in accordance with the regulations and Board Rules. The Board's review and determination are set forth below.

Pertinent Facts:

On March 4, 2024, Castor Home Nursing Inc (the "Provider") filed an *optional* group appeal request with the Board to establish Case No. 24-1461G. The Board notes the appeal was filed on behalf of a ***single*** Provider that received a letter entitled "Notice of Quality Reporting Program Noncompliance Decision Upheld" ("Noncompliance Determination") on January 2, 2024.

However, apart from the final determination, the Provider's appeal request did not include:

- the original quality reporting payment decision from CMS in which the payment reduction was identified (preliminary decision) (Board Rule 7.1.2.4);
- an issue statement (Board Rule 7.2);[1]
- a reimbursement impact on the facility, including a calculation of the amount in controversy (Board Rule 6.4); and
- a representation letter (Board Rule 5.4).

Additionally, the appeal was filed in OH CDMS using the *optional* group appeal format even though it appears to be for only a single Provider (Castor Home Nursing Inc). In this regard, the Board notes that an *optional* group is used when there are ***multiple*** *unrelated* providers seeking to appeal a factual or legal question common to them for their fiscal year that ends in the same calendar year. Further, in order for an optional appeal to be valid, Board Rule 12.6.2 explains that "[o]ptional group

[1] Board Rules Version 3.2 (Dec 15, 2023)

appeals ***must*** *have a* ***minimum*** *of two different providers*, both *at* ***inception*** and at full formation of the group."[2]

Rules/Regulations:

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

42 C.F.R. § 405.1837(b) and Board Rule 12.2 address the usage and filing of group appeals, including the requirement to have two or more providers appealing a single question of fact or interpretation of law, regulation, or CMS Rulings that is common to each provider in the group. In addition, the aggregate amount in controversy for a group must be $50,000 or more. Subparagraph (c) states that the contents of the request for group appeal must include a demonstration that the request satisfies the requirements for a Board hearing as a group appeal.

42 C.F.R. § 405.1835(b) establishes the required contents for an appeal request.

> The provider's request for a Board hearing under subparagraph (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.
>
> (1) A demonstration that the provider satisfies the requirements for a Board hearing as specified in paragraph (a) of this section, including a specific identification of the final contractor or Secretary determination under appeal.
>
> (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

[2] (Emphasis added.)

> reimbursement sought for the item, and why the provider self-disallowed the item instead of claiming reimbursement for the item.
>
> (3) A copy of the final contractor or Secretary determination under appeal and any other documentary evidence the provider considers necessary to satisfy the hearing request requirements of paragraphs (b)(1) and (b)(2) of this section.[3]

Board Rules 5, 6 and 7 further address requirements related to support for the appealed final determination, availability of issue-related information, and basis for dissatisfaction. Per PRRB Rule 6.1, the Board will dismiss appeal requests that do not meet the *minimum* filing requirements as identified in 42 C.F.R. § 405.1835(b).

Board Determination:

The Board has determined that the Provider's appeal request is fatally flawed as it was not filed in accordance with the regulations at 42 C.FR. §§ 405.1837 and 405.1835(b) and with the Board Rules.

First, the Provider does not meet the *regulatory requirements for an optional group appeal* before the Board. 42 C.F.R. § 405.1837 and Board Rule 12.6 discuss the mandatory and optional group appeals must have a *minimum of **two** different providers* and that each provider must satisfy the individual appeal requirements in 42 C.F.R. § 405.1835 (*except for the $10,000 individual appeal threshold*). Those requirements state the matter at issue must involve a single question of fact or interpretation of law, regulation or CMS Ruling and the aggregate amount in controversy for all providers will meet a $50,000 threshold.

Second, the Provider's appeal request failed to include an issue statement consistent with the appeal request content requirements in 42 C.F.R. § 405.1835(b) and Board Rule 7.2. In lieu of an issue statement, the provider submitted its Noncompliance Determination. While this document identifies the final determination under appeal per 42 C.F.R. § 405.1835(b)(1), it does not include an explanation of why, and a description of how, the provider is dissatisfied with the specific aspects of the determination as required in § 405.1835(b)(1).

Third, the provider failed to document the amount in controversy as required by 42 C.F.R. § 405.1835(a)(2) and Board Rule 6.4. Since the Provider does not meet the regulatory requirements for a group appeal, the Provider must demonstrate that it has a total amount in controversy of at least $10,000 at the time of filing. See 42 C.F.R. §§ 405.1835 and 405.1839. An identification of the reimbursement impact with a calculation to support that estimated amount must be provided with the appeal.

Additionally, the Provider has failed to submit several other documents that are required by Board Rules, including the original quality reporting payment decision from CMS in which the payment reduction was identified (preliminary decision) (Board Rule 7.1.2.4) and a representation letter (Board Rule 5.4).

Accordingly, the Board hereby dismisses Case No. 24-1671G since the appeal request is fatally flawed and does not meet the *minimum* filing requirements as outlined above.

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[3] Emphasis added.

Based on the final determination date, the Provider may still be within its appeal period. Therefore, if the Provider elects, it may refile in OH CDMS *as an individual provider appeal*. Please see 42 C.F.R. § 405.1835 and Board Rules 6 and 7, which both discuss *individual provider appeal rights* ***and*** *requirements*. Since the Provider is appealing a Quality Reporting determination, the Board directs the Provider's attention the Frequently Asked Questions ("FAQs") for Quality Reporting Appeals posted on the Board's website at https://www.cms.gov/files/document/faqs-quality-reporting-appeals.pdf.

Based on the above, the Board closes this case 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 105.1877.

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For the Board:

3/11/2024

X Clayton J. Nix

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Via Electronic Delivery

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RE: ***Recission of EJR & Closure of Group Appeals Per 42 C.F.R. § 405.1842(h)(3)(iii)***[1]
Case No. 14-2497GC *et al.* (*see* Attached listing marked as Appendix A)

Dear Messrs. Ravindran and Berends:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on **May 12, 2022** involving, in the aggregate, twelve (12) group cases and (32) participants. As discussed in further detail *infra*, the Group Representative ***belatedly*** *notified the Board on August 30, 2022* that it had filed a complaint more than 4 months earlier, on April 20, 2022, in the U.S. District Court for the Central District of California ("California Central District Court"),[2] and significantly, the April 20, 2022 filing of this Complaint occurred ***more than 3 weeks before the EJR request for the above-captioned cases was even filed with the Board***.[3]

[1] In review of its docket, the Board has identified these cases that are similar to other QRS cases involving the same type of closure circumstances triggered by 42 C.F.R. § 405.1842(h)(3)(iii) as needing to be closed but, unfortunately, were not closed earlier. *See also infra* notes 40-42 and accompanying text discussing the 642 group cases involving 2000+ participants that were filed during this time period and the complex procedural history surrounding that concentrated volume of EJR requests.

[2] *Cleveland Clinic, et al v. Becerra*, Case No. 2:22-cv-02648 (C.D. Cal. filed April 20, 2022).

[3] In its letter dated August 30, 2022, QRS *represented* to the Board that: (1) it filed the Complaint attached as Exhibit 1 to that letter in the California Central District Court to establish Case No. 2:22-cv-02648 and (2) that Complaint encompassed, among others, the instant 12 CIRP group cases covered by the May 12, 2022 *consolidated* EJR request. Accordingly, QRS asserted in its August 30, 2022 letter that "the Board does not possess jurisdiction over the captioned cases." The public docket for this litigation also shows that QRS filed an Amended Complaint on May 13, 2022, merely 1 day ***after*** QRS filed the consolidated EJR request in the instant 12 CIRP group cases. Regardless of whether the instant 12 CIRP groups cases were encompassed by the original April 20, 2022 Complaint or added to the litigation through the May 13, 2022 Amended Complaint, it does not change the Board's decision reflected in this letter. In this regard, the Board notes that the Amended Complaint was filed *one day after the filing of the consolidated EJR request* and, if the instant 12 CIRP group cases were added to the litigation at that time, it still would demonstrate that QRS had no intention of permitting the Board to complete its review of the EJR request in the first instance because as soon as the Providers filed their complaint in federal district court, the Board was obligated to cease further proceeding pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), which states: "***If the lawsuit is filed*** before a final EJR decision is issued on the legal question, the Board may **not** *conduct any further proceedings* on the legal question or the matter at issue until the lawsuit is resolved." So the fact remains that § 405.1842(h)(3)(iii) prohibited the Board from acting or processing the EJR request upon either the advance filing of the Complaint on April 20, 2022 or next-day filing of the Amended Complaint on May 13, 2022. For purposes of simplicity, this letter only discusses QRS' representation; however, that discussion applies to that alterative scenario involving the Amended Complaint since the difference between the 2 is inconsequential.

On **June 3, 2022**, the Board issued to the parties a "Status of EJR Request & Notice of When the 30-Day Period Commences." This Notice confirmed that "the 30-day period for responding to the EJR requests has not yet commenced for these [12] CIRP group appeals and will not commence until the Board completes its jurisdictional review of the these CIRP groups."[4] As part of its detailed explanation, the Board noted that "in implementing 42 U.S.C. § 1395oo(f)(1), the Secretary has made clear at 42 C.F.R. § 405.1842 that the 30-day period 'does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.'"[5] Significantly, QRS did not file any objection to this Notice.

On **June 10, 2022** (less than 30 days after the May 12, 2022 consolidated EJR request was filed), the Board issued an EJR determination on 8 of the 12 CIRP group cases encompassed by the consolidated EJR request – Case Nos. 14-2497GC, 14-2499GC, 14-2493GC, 14-2494GC, 15-3434GC, 15-3435GC, 17-0014GC, 17-0015GC. Specifically, the Board's EJR determination found jurisdiction over *and* granted EJR for "the legal questions of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid; and, if not, what policy should then apply which, per the 9th Circuit decision in *Empire* but contrary to the Provider's position, is the Secretary's policy in effect prior to the FY 2005 IPPS Final Rule that excluded no-pay Part A days from the Medicare fraction and (to the Provider's dissatisfaction[6]) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible." The Board will hereinafter refer to this set of 8 CIRP group cases as "Group A Cases" as reflected in **Appendix A**. When the Board issued this determination, it was not aware that QRS had already filed litigation covering the Group A Cases and, had it known of that Complaint, would not have issued that determination consistent with 42 C.F.R. § 405.1837(h)(3)(iii).

Following the June 10, 2022 EJR determination, there were 4 CIRP group cases left pending – Case Nos. 14-4357, 14-4358GC, 15-2396GC and 15-2397GC. The Board will hereinafter refer to this set of 4 CIRP group cases as "Group B Cases" as reflected in **Appendix A**.

Prior to the consolidated EJR request being filed, the Medicare Contractor had filed a Jurisdictional Challenge in each of the Group B Cases. Specifically, on October 23, 2014 in Case Nos. 14-4357 and 14-4358GC and June 2, 2015 in Case Nos. 15-2396GC and 15-2397GC, Federal Specialized Services ("FSS"), the Medicare Contractors' representative, and the Medicare Contractor raised jurisdictional concerns regarding the initial provider, Scottsdale Thompson Peak Medical Center (Prov. No. 03-0123), used to establish the Group B Cases because this provider neither claimed a DSH payment on its as-filed cost report for the fiscal years at issue, nor did it include any protested amounts for the group issue on those same as-filed cost reports. When the consolidated EJR request was filed, the Board had not yet ruled on the Jurisdictional Challenges and, as a result, Scottsdale Thompson Peak Medical Center was still a participant in each of the Group B Cases.

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[4] Board letter dated June 3, 2023 for Case Nos. 14-2497GC, *et al*. at 1.
[5] *Id.* at 3 (quoting 42 C.F.R. 405.1842(b)(2) (emphasis added)).
[6] The EJR determination had a footnote here stating: "Again, the Provider is located in the Ninth Circuit. Accordingly, in this situation, the Provider goes beyond *Empire* and contends that the Secretary's prior policy of excluding from the numerator Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid."

Accordingly, on **June 11, 2022**,[7] the Board issued a Request for Additional Information (RFI") and Scheduling Order ("RFI Scheduling Order") for each of the Group B Cases to obtain certain information to confirm whether Thompon Peak did or would qualify for a DSH payment adjustment for purposes of establishing a basis for dissatisfaction. The RFI Scheduling Order set July 5, 2022 as the due date for QRS to file its response and also reaffirmed that "the 30-day period allowed for Board consideration of an EJR request has not yet begun because, as stated at 42 C.F.R. § 405.1842(b)(2), 'the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.'"[8]

On **July 5, 2022**, QRS withdrew Scottsdale Thomson Peak Medical Center (Prov. No. 03-0123) from each of the Group B Cases without any explanation or discussion of the RFI Scheduling Order.

On **August 2, 2022**, the Board issued a Scheduling Order for Additional Briefing on the EJR Request ("Order for Additional Briefing") due to the issuance of the Supreme Court's decision in *Becerra v. Empire Health Foundation* ("*Empire*")[9] *after* QRS filed the instant EJR request. Since the *Empire* decision was directly relevant to the issues in the EJR Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue the Order for Additional Briefing requiring QRS to file a response within 28 days (*i.e.*, by August 30, 2022) to provide the following information:

1. Giving updates on whether the groups' participants were still pursuing the EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating, or clarifying as relevant, the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[10]

Finally, the Order for Additional Briefing: (1) noted that the June 11, 2022 RFI Scheduling Order notified the parties that "the 30-day period for Board review of an EJR request does not begin until the Board finds jurisdiction and since the Board has not yet completed its jurisdictional review, the 30-day period had not yet begun"; and (2) "[t]his notice remains in effect as the Board has not yet completed its jurisdictional review."[11]

Following the Board's Order for Additional Briefing, QRS did not file any objections or requests for clarification with regard to the Order itself. As a result, the Board and FSS continued to take actions consistent with that Order. The Medicare Contractors were required to file, through FSS,

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[7] Note – June 11, 2022 was the 30th day from the date the Consolidated EJR request was filed.
[8] Board RFI Scheduling Order at 1 (June 11, 2022) (footnote omitted).
[9] 142 S. Ct. 2354 (2022).
[10] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (see 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. See 42 C.F.R. § 405.1842(f)(2)(iii).
[11] Board Scheduling Order for Additional Briefing at 1 (Aug. 2, 2022) (footnote omitted).

any reply to the Group Representative's response no later than 28 days after the filing date of the response.

On **August 30, 2022**, the Group Representative filed a timely response to the Order for Additional Briefing. Within its response, QRS represented to the Board that they had commenced an action in federal court on April 20, 2022 for both the Group A Cases and Group B Cases (as evidenced by the April 20, 2022 Complaint attached as Exhibit 1) and then served the Secretary of Health and Human Services, 3½ months later, on August 7, 2022. It insisted that the Board now lacked jurisdiction to dismiss or take any action in the Group B Cases as a result of its federal court filing. It nevertheless argued, at this late date, that the appeals at issue here all included challenges to an alternate issue (whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction).

Accordingly, QRS has *represented* that it filed litigation to pursue the Group A Cases and Group B Cases one-hundred eleven (111) days *prior to its August 30, 2022 notice to the Board* and, more egregiously, ***thirteen (13) days BEFORE the EJR request was filed with the Board***.[12] Specifically, on April 20, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the *yet-to-come* EJR and jurisdictional review process by filing a complaint in the California Central District Court under Case No. 2:22-CV-02648 seeking judicial review on the merits of its EJR Request in the Group A Cases and Group B Cases.[13] Through operation of 42 C.F.R. § 405.1842(h)(3)(iii), which states: "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved[]," the Board could conduct no further proceedings in the Group A Cases and Group B cases upon the filing of the Complaint. Thus, the fact that QRS filed a federal district court complaint ***before*** it filed its EJR request[14] demonstrates that QRS had *no intention* of allowing the Board to process its EJR requests, pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to ***immediately*** notify the Board and the opposing parties of this litigation filing demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix C**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board to] respond[] to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of

[12] *See supra* note 3.
[13] Case No. 2:22-CV-02648 also includes numerous other appeals and hundreds of providers which have been addressed under separate cover.
[14] *See supra* note 3.

these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states, in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii) states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 (Nov. 2021) states, in pertinent part:

> Board jurisdiction must be established **prior to** granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue **prior to** granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** *it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.[15]

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

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS file any objections to the Scheduling Orders issued in these cases.

QRS made clear by filing the Complaint in federal district court on April 20, 2022, that it was bypassing and abandoning the Board's prerequisite jurisdictional review process and processing of the EJR request within the time allotted under 42 U.S.C. § 1395oo(f)(1) as implemented by the Secretary at 42 C.F.R. § 405.1842.

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. For example, how is the Court to know that subsequent to the litigation being filed by QRS to pursue the merits of the Group A Cases and Group B Cases that, as discussed *supra*, QRS withdrew a participant from the Group B Cases? Did it similarly withdraw this participant from the federal litigation being pursued? To further illustrate this very point, the Board has included as **Appendix C**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

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[15] (Italics emphasis in original, and bold and underline emphasis added.)

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a federal lawsuit *prior to filing the Consolidated EJR request* in connection with the above-referenced twelve (12) group cases.[16]

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[17]

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

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question

[16] *See also supra* note 3 discussing that, if QRS erred in its representation, the pursuit of the Group A and B Cases in federal court occurred on May 13, 2022 ***at the latest***. This would be just one day after the EJR request being filed and would not change this finding.
[17] (Emphasis added.)

> (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
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> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
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> ****
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> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
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> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
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> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.
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> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue <u>before</u> the Board may determine its authority to decide the legal question**.
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> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **<u>the 30-day period</u> for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **<u>does not begin to run until the Board finds jurisdiction to conduct a hearing</u> on the specific matter at issue in the EJR request <u>and</u> notifies the provider that the provider's request is complete**.[18]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the

[18] (Emphasis added).

provider's request is complete."[19] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[20]

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

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[21] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[22] The Court in *Alexandria* continued, stating:

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[19] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).

[20] (Emphasis added.)

[21] 42 U.S.C. § 1395oo(f)(1) (emphasis added).

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

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
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> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[23]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[24] Not only are the federal trial courts ill-suited for making such determinations, but it is a task assigned to the Board, *by statute*.

Significantly, in the Group B Cases, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. The Board stopped this process after it learned that QRS had bypassed the completion of this process even before the EJR request had been filed. Having an opportunity to complete the

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

[24] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 3, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 19, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

jurisdictional and substantive claim review[25] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these four (4) group cases encompassed in the Group B cases as highlighted in **Appendix B**.

For the Group A Cases, the Board issued the June 10, 2022 EJR determination with the understanding that the cases were still pending before it. However, as the Board later learned on August 30, 2022, QRS had already commenced pursuit of the merits of the Group A Cases in federal district court on April 20, 2022. The regulation at 42 C.F.R. § 405.1842(h)(3)(iii) makes clear that because "the lawsuit [wa]s filed before a final EJR decision [wa]s issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved." Accordingly, the June 10, 2022 EJR determination violates this regulation and, as such, was void in the first instance.[26]

The above discussion makes it unmistakable that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process *and* finds jurisdiction.[27] QRS' filing of the Complaint in federal district court ***13 days before the EJR Request was filed***, without notice to the Board or opposing parties, is contemptuous of the Board's authority.[28] It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request as it relates to both the Group A Cases and the Group B Cases.

B. Effect of QRS' Advance or Concurrent Filing of the Complaint on the 6 Group Cases

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

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at

[25] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[26] The alternative situation described, *supra*, in note 3, if true, would not change this finding.
[27] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).
[28] The alternative situation described, *supra*, in note 3, if true, would not change this finding.

> issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.
>
> ****
>
> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[29]

Thus, once "the lawsuit is filed," this regulation ***bars any further Board proceedings*** relating to the *consolidated* EJR request filed in the Group A and Group B Cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. As a result, the Board's June 10, 2022 EJR determination issued for the Group A Cases was void in the first instance and the Board hereby rescinds that determination in recognition of that fact. Further, consistent with FRCP 62.1, the Board is deferring any further action in the Group A and Group B Cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[30] and the May 23, 2008 final rule[31] which promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[32]

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

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that

[29] (Emphasis added.)
[30] 69 Fed. Reg. 35716 (June 25, 2004).
[31] 73 Fed. Reg. 30190 (May 23, 2008).
[32] 69 Fed. Reg. at 35732.

> the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[33]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' *advance* filing of the Complaint in the District Court on April 20, 2022 (13 days prior to the filing of the EJR request) prohibited the Board from conducting any further proceedings on the consolidated EJR request for the Group A and Group B Cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements. As such, the Board's issuance of the June 10, 2022 EJR determination was void in the first instance and is hereby rescinded in recognition of that fact.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court litigation to pursue the merits of the Group A and B Cases is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided at 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice

[33] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[34] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.

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

> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[35]

Indeed, the following action (or inaction) by QRS reinforces the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS failed to notify the Board that it had already filed a lawsuit on April 20, 2022 to pursue the merits of the Group A and B Cases ***13 days prior to*** filing the May 12, 2022 *consolidated* EJR request for these cases, notwithstanding the fact that the EJR process is the only procedural process that allows the groups to bypass the Board's administrative review process.

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling on that the 30-day period to review the EJR request had not yet begun, and the associated Scheduling Orders for the Group A and B Cases reaffirming that ruling. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[36] It also resulted in the Board issuing its June 10, 2022 EJR determination in error, because, had the Board known that a lawsuit had already been filed in advance of the consolidated EJR request, it would not have issued that determination consistent with 42 C.F.R. § 405.1842(h)(3)(iii).

3. QRS can make no claims that it was harmed by any delay caused by the Board's Scheduling Orders notifying QRS that the 30-day period to process the EJR request had not yet begun due to additional time needed for the Board to complete its jurisdictional review when QRS filed a federal district court case ***before filing its EJR request.***

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

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

4. The Board made known to the parties in the Group A and B Cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[37] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its initial Scheduling Order on June 3, 2022 for the Group A and B Cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request and then reaffirmed that ruling in subsequent Scheduling Orders dated June 11, 2022, and August 2, 2022. QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[38] or take other actions, ***prior to*** QRS filing its April 20, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow initiation of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges the Board missed in its federal litigation)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[39]

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court for the Group A and B Cases violates Board Rule 1.3, and caused both the Board and the Medicare Contractors to waste time and administrative resources when the Board was prohibited from taking any further action on the Group A and B Cases appeals pursuant to 42 C.F.R. § 405.1842(h)(3)(iii).

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, April 20, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it hijacked the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to cease work on the Group A and B Cases in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the Board, and the opposing parties, of this lawsuit filed in the California Central District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other

[37] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[38] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 17-24 and accompanying text.
[39] *See supra* note 36 (discussing how the FRCP supports the Board's position).

representatives for EJR requests filed for the same issue.[40] The prejudicial sandbagging is highlighted by the facts that:

1. During the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[41]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that, without concurrent notice to the Board, QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509 and the April 20, 2022 Complaint at issue in this letter was jointly filed by QRS and HRS covering 150+ ***other*** cases.[42]

It is clear the Providers are pursuing the merits of their cases in the Group A and B Cases as part of their lawsuit in the California Central District Court.[43] Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[44]

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and

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

[41] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS, *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in federal district courts for California and the District of Columbia. *See infra* notes 32 and 33 and accompanying text.

[42] The Board is addressing the cases impacted by this litigation under separate cover.

[43] This is notwithstanding the Board's dismissal of 2 of these group cases.

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

abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded for further proceedings*, the Board will complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[45] Examples of available remedial actions that the Board may consider taking in the Group A and B Cases to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the Group A Cases and/or Group B Cases and all underlying participants.

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

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

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[46] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board

[45] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

[46] 42 C.F.R. § 405.1868 states:

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

(Emphasis added.)

> authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
>
> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[47]

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

E. Board Decision and Order

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

1. Closes the Group B Cases[48] consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Rescinds the June 10, 2022 EJR determination as it relates to the Group A Cases and then closes those cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii) because "the lawsuit [wa]s filed before a final EJR decision [wa]s issued on the legal question, [thus] the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved" and accordingly, the Board's June 10, 2022 EJR determination was void.
3. Suspends the ongoing jurisdictional review process for the Group B Cases; and
4. Defers consideration of citing QRS for contempt and dismissing these group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[49]

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[47] 73 Fed. Reg. at 30225.
[48] *See supra* note 2 and accompanying text.
[49] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance.

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

Board Members Participating:

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

For the Board:

3/11/2024

X Clayton J. Nix

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

Enclosures:

Appendix A – Case List
Appendix B – Interim List of Potential Jurisdictional & Procedural Violations Under Review for the Group A and B Cases
Appendix C -- June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: John Bloom, Noridian Healthcare Solutions (JF)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

APPENDIX A

Grouping A – List of the 8 Group Cases
Covered by the Request for EJR
Filed on May 12, 2022

GROUP A CASES—Cases covered by the Board's May 10, 2022 EJR determination that the Board is now rescinding and closing:

14-2497GC	QRS Scottsdale HC 2007 DSH SSI Fraction Dual Eligible Days CIRP
14-2499GC	QRS Scottsdale HC 2007 DSH Medicaid Fraction Dual Eligible Days CIRP
14-2493GC	QRS Scottsdale HC 2008 DSH Medicaid Fraction Dual Eligible Days CIRP
14-2494GC	QRS Scottsdale HC 2008 DSH SSI Fraction Dual Eligible Days CIRP
15-3434GC	QRS Scottsdale HC 2010 DSH SSI Fraction Dual Eligible Days CIRP Group
15-3435GC	QRS Scottsdale HC 2010 DSH Medicaid Fraction Dual Eligible Days CIRP
17-0014GC	QRS HonorHealth 2013 DSH SSI Fraction Dual Eligible Days CIRP Group
17-0015GC	QRS HonorHealth 2013 DSH Medicaid Fraction Dual Eligible Days CIRP Group

GROUP B CASES—Additional cases closed by the Board:

14-4357GC	QRS Scottsdale HC 2011 - DSH SSI Fraction Dual Eligible Days CIRP Group
14-4358GC	QRS Scottsdale HC 2011 - DSH Medicaid Fraction Dual Eligible Days CIRP Grp.
15-2396GC	QRS Scottsdale HC 2012 - SSI Fraction Dual Eligible Days CIRP Group
15-2397GC	QRS Scottsdale HC 2012 - DSH Medicaid Fraction Dual Eligible Days CIRP Grp.

APPENDIX B

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW RELATIVE TO THE GROUP A AND B CASES[50]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process *relative to both the Group A and B Cases*.[51] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases and when many of those cases are older cases (7+ years old).

With respect to the Group B Cases, the Board, through its ongoing review of jurisdiction and other procedural issues, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board's review is based on the SoPs filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[52] the SoPs are supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) for the Group B Cases include, but are not limited to, the following:

1. *Effects of the Post-Litigation Withdrawal of A Participant from the Group B Cases*.—The withdrawal of Scottsdale Healthcare Thompson Peak from each of the Group B Cases occurred after QRS filed the lawsuits in the California Central District Court. Thus, it is unclear whether those withdrawals have been or will be accounted for in the ongoing litigation on the merits. Further, the withdrawal of this participant from Case No. 14-4359GC resulted in the group falling below the minimum $50,000 amount in controversy requirement ("AiC") for a group appeal as the AiC is now $45,070 (*i.e.*, $22,054 + $23,016). As explained in 42 C.F.R. § 405.1839(b), "[i]n order to satisfy the amount in controversy [or AiC] requirement . . . for a Board hearing as a group appeal, the group must *demonstrate* that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."[53] Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ."[54]

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[50] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 36 group cases.

[51] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[52] *See also* Board Rule 20.1 (Aug. 2018).

[53] (Emphasis added.)

[54] (Emphasis added.) Consistent with 42 C.F.R. §§ 405.1840(a) and 405.139(b), Board Rule 6.4 (2018) (as also cross-referenced in Board Rule 21.6.1 (2018)) requires that "*[f]or each issue*, provide a calculation or support demonstrating the amount in controversy." (Emphasis added.)

2. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in the Group B Cases arrived by transfer from an individual provider appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[55] The Board expects it may identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

3. *Open Procedural Issues in the Group B Cases Following the Supreme Court's Decision in Empire*.—On the August 2, 2022, the Board ordered QRS to confirm whether it was still pursuing each of the Group B Cases notwithstanding the Supreme Court's decision in *Empire* and for each case being pursued:

> [U]pdate[] the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction (and excluding the subset of days involving dually eligible patients from the numerator of the Medicaid fraction). As relevant, to the extent you assert that one or more of the above-captioned group cases contain additional separate issues outside of the challenge to the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction (and related Medicaid fraction numerator issue), then you must, in each group case: (a) identify any such additional issues; (b) explain how the Board has jurisdiction over each additional issue and how such issue is validly part of the relevant group case (including how it is included in the original group issue statement, and how there are separate amount in controversy ("AiC") calculations for the additional issue in the final Schedule of Providers behind Tab E for each participant consistent with 42 C.F.R. § 405.1839(b)); and; (c) request that the Board bifurcate each additional issue from the relevant group.

The Board has not yet had an opportunity to review QRS' response.

QRS' August 30, 2022 letter responding to the Board August 2, 2022 Scheduling Order raises issues for the both Group A and B Cases. In that letter, QRS asserts that "with the proceedings in *Empire Health Foundation* in mind, and to respond directly to the Board's inquiry, the Providers in the captioned cases **likewise appeal** the alternate issue, *i.e.*, of whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction. The Providers' complaint filed in the California Central District

[55] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

Court includes allegations, and request for relief, regarding the alternate issue." It appears that QRS has either added to its appeal an alternate issue or that its original group appeals for the Group B Cases encompassed more than one issue notwithstanding the following regulatory requirements:

(1) 42 C.F.R. § 405.1837(a)(2) requiring that "[t]he matter at issue in the group appeal involves a ***single*** *question of* . . . ***interpretation*** of law, regulations, or CMS Rulings that is common to each provider in the group";[56]

(2) 42 C.F.R. § 405.1837(c)(3) requiring that each group appeal request include "a ***precise*** *description of the one question of* . . . ***interpretation*** of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal";[57] and

(3) 42 C.F.R. § 405.1837(a)(3) requiring that "[t]he amount in controversy [for a group appeal] is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart" which, in particular, requires at 42 C.F.R. § 405.1839(b)(2)(i), that "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** *allowed to aggregate claims involving* ***different issues*** . . . . [since a] A group appeal must involve a ***single*** question of . . . ***interpretation*** of law, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart)."[58]

In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue and the group appeal must document that it meets the amount in controversy for that one issue.[59] The Board is reviewing the Group B Cases to determine whether, as asserted in the August 30, 2022 QRS letter, the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[60]) in

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

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

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

addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[61]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[62] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[63] and, as relevant, whether it requested transfer of those additional issues to the group and documented a separate amount in controversy for the alleged additional issue; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[64]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2) ***at this late stage*** *of the appeal when* ***all*** *jurisdictional documentation is* ***already*** *required to be part of the record*. A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. As noted, the Board flagged this issue in its August 2, 2022 letter, and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process. *Indeed, to the extent,* ***the Group A Cases*** *are remanded back to the Board and the QRS makes similar claims regarding an* "*alternative issue*," ***the Board would also need to conduct this same jurisdictional inquiry to determine the scope of the Group A Cases and whether ERJ would continue to be appropriate given the subsequent legal development of the Supreme Court's Empire decision***.[65] In this regard, the Board notes that it must revisit the Group A Cases because QRS did not even wait 29 days until the June 10, 2022 EJR determination but rather bypassed the Board's EJR review process by pursuing the merits of the Group A Cases in federal district court through its Complaint filed on April 20, 2022.[66]

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the April 20, 2022 filing of the Complaint in federal district court ***13 days in advance of the May 12, 2022 consolidated EJR request***, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above) as it relates to both the Group A and B Cases.

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

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

[63] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.

[64] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include: Case Nos. 21-0237G, 21-0273G and 21-0239G where the position paper was filed in January 2022.

[65] The Borad notes that the Board found the consolidated EJR determination to be limited to the "legal questions of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid; and, if not, what policy should then apply which, per the 9th Circuit decision in *Empire* but contrary to the Provider's position, is the Secretary's policy in effect prior to the FY 2005 IPPS Final Rule that excluded no-pay Part A days from the Medicare fraction and (to the Provider's dissatisfaction) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible." Note each of these legal questions was specified and pursued in a separate and district CIRP group where each provider participated in 2 separate CIPR groups for each year where one CIRP group covered one legal question and the other CIRP group covered the other legal question.

[66] *See supra* note 3.

APPENDIX C

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

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[74]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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

For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

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

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision***
Northern Louisiana Medical Center (Prov. No. 19-0086)
FYE 09/30/2014
Case No. 19-0318

Dear Messrs. Ravindran and Redmond:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case the above captioned appeal. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-0318

On April 26, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2014. On October 29, 2018, the Board received the Provider's individual appeal request. The appeal request contained the following fiveissues:

1. DSH/SSI Percentage (Provider Specific),
2. DSH/SSI Percentage (Systemic Errors),[1]
3. DSH Payment Medicaid Eligible Days,
4. UCC Distribution Pool, and
5. 2 Midnight Census IPPS Payment Reduction.[2]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider directly added Issue 2 and transferred Issue 5 to Community Health groups. On March 1, 2024, the Provider withdrew Issue 3 from the appeal. As a result, the remaining issues in this appeal are DSH Payment/SSI Percentage (Provider Specific) (Issue 1) and UCC Distribution Pool (Issue 4).

[1] On Oct. 13, 2018, this issue was directly added to CIRP group PRRB Case No. 16-1192GC. The Board notes the Provider also transferred Issue 2 to CIRP group PRRB Case No. 18-0109GC (QRS CHS 2014 DSH SSI Percentage CIRP Group) on May 22, 2019. However, on June 13, 2023, the Board closed case no. 18-0109GC as a duplicate of case no. 16-1192GC.
[2] On May 22, 2019, this issue was transferred to PRRB Case No. 18-0112GC.

On June 13, 2019, the Provider submitted its preliminary position paper. On September 26, 2019, the Medicare Contractor filed its preliminary position paper.

On December 27, 2023, the Provider filed its Final Position Paper. On January 25, 2024, the Medicare Contractor filed its Final Position Paper.

The Medicare Contractor has filed two jurisdictional challenges in the appeal. On April 18, 2019, the Medicare Contractor challenged jurisdiction over Issues 1, 2, 4 and 5. The Provider filed a jurisdictional response to this challenge on May 15, 2019. On January 24, 2024, the Medicare Contractor filed a second jurisdictional challenge, noting that a Board ruling is required for Issues 1 and 4 in this appeal.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 16-1192G

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) (Issue 1) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[3]

As the Provider is commonly owned by Community Health, the Provider was directly added to the CIRP group under 16-1192GC, Community Health Systems 2014 DSH Post 1498R SSI Data Match CIRP Group, on October 13, 2018. The Group Issue Statement in Case No. 16-1192GC reads:

> The failure of the Fiscal Intermediary and [CMS] to properly determine the ratio of patient days for patients entitled to Medicare Part A and Supplemental Security Income (SSI) benefits (excluding any State supplementation) to patient days for patients entitled to Medicare Part A (Medicare Proxy or Fraction) for the Provider in its Disproportionate Share Hospital (DSH) eligibility determination and payment calculation, including any related impact on capital DSH. The Provider asserts that the Medicare Proxy is improperly understated due to a number of factors, including CMS's inaccurate and improper matching or use of data along with policy changes to determine both the number of Medicare Part A SSI patient days in the numerator of the fraction and the total Medicare Part A

[3] Appeal Request, Tab 3 Appeal Issues at 1 (Oct. 26, 2018).

patient days in the denominator, as utilized in the calculation of the Medicare percentage of low income patients for DSH purposes and/or low income patient (LIP) adjustment for Inpatient Rehabilitation Facilities (IRFs) and/or IRF units.

CMS's improper treatment and policy changes resulted in an underpayment to the Providers as DSH program eligible providers of services to indigent patients, and includes any other related adverse impact to DSH payments, such as reduced capital DSH payments or LIP adjustments. Also, this treatment is not consistent with Congressional intent to reimburse hospitals for treatment of indigent patients when determining DSH program eligibility and payment pursuant to 42 U.S.C. § 1395ww(d)(50(F), 42 C.F.R. § 412.106, Medicare Intermediary Manual § 3610.15, or any other applicable statutes, regulations, program guidelines, or case law.

On March 22, 2006, the Provider Reimbursement Review Board (PRRB) issued a decision in the Baystate case that was favorable to the provider. The PRRB identified significant flaws in the compilation of Medicare SSI days and held, among other things, that: 1) the law requires accuracy in the reporting of SSI days; 2) the PRRB has the authority to require CMS to recalculate the SSI Percentage if necessary; and 3) there would not be a significant administrative burden required to redesign CMS's computer programs and processes to more accurately identify Medicare SSI eligibility.

The PRRB's decision was supported by the March 31, 2008, D.C. District Court decision which found CMS did not use the most reliable data available to determine which patient days should be counted in the SSI percentage and that such was "arbitrary and capricious." The Court additionally held that if an agency has sole possession of the information needed by an opposing party to prove its claim, then it cannot simply reject the party's allegations based upon the party's lack of proof.

CMS issued Ruling 1498-R on April 28, 2010 in response to the Baystate court decision. This significant Ruling sets forth, among other things, a revised and corrected data match process CMS would use to determine Providers' appropriate Medicare proxies and overall DSH adjustments. Providers assert that errors and problems still exist in the data match process, as well as improper policy changes by CMS, which are resulting in understated DSH adjustments for Providers, including the failure to include all Dual Eligible (Medicare/Medicaid) patient days in the Medicare fraction numerator as intended by Congress or alternatively in the Medicaid fraction numerator. CMS asserts in Ruling 1498-R that su.ch Dually Eligible/Crossover days, including such days that are Medicare

> Non-Covered days, are being included in the Medicare proxy for discharges occurring on or after October 1, 2004. Providers assert that all such days are not properly being captured in the Medicare proxy of the DSH and/or LIP calculation.

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $26,000.

On June 13, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH payments are not in accordance with the Medicare statute 42 U.S.C. 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Louisiana and the Provider that does not support the SSI percentage issued by CMS. The Provider has worked with the State of Louisiana and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000, 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. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its SSI percentage based on CMS admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[4]

[4] Jurisdictional Challenge (Jan. 24, 2024), Ex. C-2 "Provider's Preliminary Position Paper" at 8-9.

Medicare Contractor's Position

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) for two reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final MAC determination. A provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The MAC also contends that the Board lacks jurisdiction over the SSI realignment portion of Issue 1. This issue should be dismissed. There was no final determination over SSI realignment. Additionally, as the Provider's [Fiscal Year] is the same as the federal fiscal year (10/1 – 09/30) the SSI percentage is already calculated to the Provider's fiscal year and any assertion of rights to realignment is superfluous.[5]

In addition, the MAC argues the data accuracy and "eligible for SSI but did not receive SSI payment" components of Issue 1 are duplicative of Issue 2 which is being appealed in PRRB Case No. 16-1192GC.[6]

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[7]

Provider's Jurisdictional Response

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The Provider contends that Issues 1 and 2 are separate and distinct issues which represent different aspects of the SSI Percentage. The Provider claims that Issue 1 addresses "errors of omission and commission" which are outside of the systemic errors described in Issue 2. Regarding Issue 1, the Provider states the SSI percentage is understated as "the Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI that are not included in the SSI percentage. . ."

[5] Jurisdictional Challenge at 3-4 (Apr. 18, 2019).
[6] *Id*. at 2.
[7] Jurisdictional Challenge at 6 (Apr. 18, 2019).

and these errors may be or are specific to the Provider. The Provider requests that the Board find it has jurisdiction over Issue 1.[8]

Issue 4 – UCC Distribution Pool.

The Provider argues that the DSH statute dose not authorize the use of an estimate for the uninsured patient percentage, and "the Secretary should be required to reconcile her initial estimate of the uninsured patient percentage with actual data. . . ."[9] The Provider's position is that the courts can review the use of estimates for Issue 5, and therefore the Board can also review this allegation.[10] The Provider argues it is entitled to a writ of mandamus ordering the Secretary to revise its estimates,[11] and this appeal is a challenge to the regulation relied upon by the Secretary to compute the estimate for the uninsured patient percentage.[12] Specifically, the provider is challenging the "IPPS rule which incorporate the defective estimates used by the Secretary."[13]

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1, the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 16-1192GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[14] The Provider's legal basis for its DSH Payment/SSI

[8] Jurisdictional Response at 1-2 (Mar. 15, 2019).
[9] *Id.* at 3.
[10] *Id.*
[11] *Id.* at 4-5.
[12] *Id.* at 5-6.
[13] *Id.* at 6.
[14] Appeal Request, Tab 3 Appeal Issues at 1.

Percentage (Provider Specific) issue asserts 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)."[15] The Provider argues that, "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . .." and it ". . . disagrees with the [Medicare Contractor]'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."[16]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 16-1192GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 16-1192GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[17], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS' interpretation of the regulation dictating the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations. Accordingly, the Provider is pursuing that issue as part of the group under Case No. 16-1192GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[18] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1192GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 16-1192GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

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[15] *Id.*
[16] *Id.*
[17] PRRB Rules v. 2.0 (Aug. 2018).
[18] 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).

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[19]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule,

> Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year.[20]

Further highlighting the perfunctory nature of the Provider's briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the CMS and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[21] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[22]

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[19] (Emphasis added).
[20] (Emphasis added).
[21] Last accessed February 24, 2023.
[22] Emphasis added.

Indeed, the D.C. Circuit affirmed in Advocate Christ Med. Ctr. v. Becerra, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not identify what information it needs to support its claim. Nor does the Provider claim that it is waiting for, or has been denied access to, specific information necessary to prove its claim.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 16-1192GC are the same issue.[23] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[24]

[23] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[24] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who

(B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[25] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[26] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[27] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[28]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[29]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH*").[30] In *DCH*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the

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are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

[25] 830 F.3d 515 (D.C. Cir. 2016).

[26] 89 F. Supp. 3d 121 (D.D.C. 2015).

[27] 830 F.3d 515, 517.

[28] *Id.* at 519.

[29] *Id.* at 521-22.

[30] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[31] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[32]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[33] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[34] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[35] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[36] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[37]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[38]

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[31] *Id.* at 506.
[32] *Id.* at 507.
[33] 514 F. Supp. 249 (D.D.C. 2021).
[34] *Id.* at 255-56.
[35] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[36] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[37] *Id.*
[38] *Id.* at 262-64.

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[39] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[40] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[41]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[42] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[43] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[44] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH* where it "repeatedly applied a `functional approach' focused on whether the challenged action was 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[45] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[46] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive

[39] *Id.* at 265.
[40] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[41] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[42] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[43] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[44] *Id.* at *4.
[45] *Id.* at *9.
[46] 139 S. Ct. 1804 (2019).

legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[47]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2014 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DCH*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

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In summary, the Board dismisses the DSH SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 16-1192GC and there is no final determination from which the Provider can appeal the SSI realignment aspect of this issue. The Boad also dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review.

As there are no remaining issues in this appeal, Case No. 19-0318 is now closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

3/11/2024

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: PIV

cc:Wilson Leong, Federal Specialized Services

[47] *Ascension* at *8 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

Christopher Kenny, Esq.
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RE: ***Dismissal – Failure to File from an Appealable Determination***
King & Spalding FFY 2024 § 1115 Waiver Days Groups
Case No. 24-1531GC, *et al*. (*see* Attachment A of 23 cases)

Dear Mr. Kenny:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed in the twenty-three (23) § 1115 Waiver Days group appeals on Attachment A consisting of 2 *optional* groups and 21 common issue related party ("CIRP") groups. The appeals were all timely filed between February 23 and 26, 2024 from the FFY 2024 IPPS Final Rule published on August 26, 2023 and effective October 1, 2023.[1] The Board's decision related to the appeals is set forth below.

Background:

The Providers' Representative, Christopher Kenny of King & Spalding, LLP ("King & Spalding"), filed the group appeal requests to establish the above-referenced *optional* and *CIRP* group appeals. The providers were all *directly*-added to the group appeals. Each of the 21 CIRP group pertains to a chain of providers and references a specific state and a specific § 1115 waiver days program for that state. Each optional groups consists of *unrelated* providers; however, similar to the CIRP groups, each optional group references a specific state and a specific § 1115 waiver days programs for that state. The appeals are each of the federal fiscal year ("FFY") 2024 IPPS Final Rule as it relates to the Secretary's policy to include inclusion only certain § 1115 waiver days in the Medicaid fraction of the disproportionate share hospital ("DSH") payment calculation.[2] The appeals ***only*** relate to FFY 2024[3] and the appeals each contain substantially the same issue statement, but for changing out the *bracketed* State and § 1115 waiver day program references:

[1] 88 Fed. Reg. 58640 (Aug. 28, 2023) (addressing "Counting of Certain Days Associated With Section 1115 Demonstration in the Medicaid Fraction").
[2] *Id.* at 59012-26 (excerpt from the preamble to the final rule).
[3] FFY 2024 runs from October 1, 2023 through September 30, 2024. The Providers in these 23 group have fiscal years generally have fiscal years that do not coincide with the FFY 2024 and, in these instances, the Providers appealed the portions of the 2 fiscal years that fall within FFY 2024. For example, if a provider had a fiscal year ending December 31st, the provider would appealed both its fiscal year ending December 31, 2023 (*i.e*., its FY 2023 but only the last quarter of 2023 that began Oct. 1, 2023 when the policy at issue became effective) and its fiscal year ending December 31, 2024 (*i.e*., its FY 2024 but only the first three quarters of FY 2024 as FFY 2024 ends September 2024). *In this example*, the provider's FY 2023 has not yet concluded and its FY 2024 has not yet begun. As similar situation would

> This appeal challenges CMS's final determination set forth in the Inpatient Prospective Payment System Final Rule for fiscal year 2024 to deny hospitals Medicare DSH payments attributable to the inpatient days of individuals whose inpatient hospital services were eligible to be covered in whole or in part by an uncompensated care pool established under a waiver approved by CMS pursuant to Section 1115 of the Social Security Act. 88 Fed. Reg. 58640, 59016 (Aug. 28, 2023) (adopting 42 C.F.R. § 412.106(b)(4)(iii)). **Beginning on October 1, 2023, newly adopted 42 C.F.R. § 412.106(b)(4)(iii) bars hospitals from claiming in the Medicaid fraction of their Medicare DSH calculations all patient days attributable to such individuals.** This determination is unlawful because CMS is required to include in the Medicaid fraction all patients it has regarded as eligible for Medicaid under a Section 1115 waiver. 42 U.S.C. § 1395ww(d)(5)(F)(vi). Patients whose care is eligible for coverage under an uncompensated care pool that was established under a CMS approved Section 1115 waiver are regarded as eligible for Medicaid. *See Forrest General Hospital v. Azar*, 926 F.3d 221, 229 (5th Cir. 2019); *Bethesda Health, Inc. v. Azar*, 389 F. Supp. 3d 32, 47 (D.D.C. 2019) *aff'd*, 980 F.3d 121 (D.C. Cir. 2020).
>
> The Providers in this group appeal are hospitals located in the State of [Tennessee][4]. The [Tennessee] Medicaid program provides coverage to uninsured patients who receive some or all their hospital services free of charge under the hospital's charity care policy. Payments for this coverage are drawn from an uncompensated care (UC) pool authorized under the [Uncompensated Care Fund for Charity Care authorized under the TennCare III Program]—a waiver approved by the Secretary of Health and Human Services (the Secretary) pursuant to section 1115(a)(2) of the Social Security Act. Because the patients covered by [TennCare III's UC Pool] receive inpatient hospital benefits from a Section 1115 waiver, the Medicare statute regards them as eligible for Medicaid. Accordingly, the statute requires the Secretary to include the inpatient days attributable to these individuals in the Medicaid fraction of the Medicare DSH calculation. The Secretary's regulation defies this command.[5]

The Board is reviewing these appeals *sua sponte*, as the Board has previously addressed the issue in recent appeals filed by the same Provider Representative in the context of requests for

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exist if the provider's fiscal year ended July 31st where the provider would appealed both its fiscal year ending July 31, 2024 (*i.e.*, its FY 2024 but only the last three quarters of FY 2024 as FFY 2024 began October 1, 2023) and its fiscal year ending December 31, 2025 (*i.e.*, its FY 2025 but only the first quarters of FY 2025 as FFY 2024 ends September 2024). *In this second example*, the provider's FY 2024 has not yet concluded and its FY 2025 has not yet begun.

[4] Issue Statement from Case No. 24-1531GC. Each group appeal updates the State and waiver program identified in the issue statement to the state and program specific to that group appeal.

[5](Bold and underline emphasis added, and italics emphasis in original.)

expedited judicial review.[6] In this regard, the Board notes that Providers are required to demonstrate in their appeal request that the Board has jurisdiction as explained as follows in 42 C.F.R. § 405.1837(c):

> (c) *Contents of request for a group appeal*. The request for a Board hearing as a group appeal must be submitted in writing to the Board, and the request **must include all of the following**:
>
> (1) **A demonstration that the request satisfies the requirements for a Board hearing as a group appeal**, as specified in paragraph (a) of this section.
>
> ****
>
> (3) A copy of each final contractor or Secretary determination under appeal, and **any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1)** . . . **of this section**, and a precise description of the one question of fact or interpretation of law, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal.[7]

The Board further notes that it may review jurisdiction at any time consistent with 42 C.F.R. §§ 405.1837(c), (e)(2) and Board Rule 4.1[8] as confirmed in the 2022 decision of the D.C. District Court in *Memorial Hosp. of South Bend v. Becerra*.[9]

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[6] See 23-1797GC et al dismissed October 25, 2023; 24-0075GC et al dismissed November 14, 2023; 24-0599GC dismissed January 19, 2024 and 24-0629 dismissed January 23, 2024.

[7] (Italics emphasis in original, and bold and underline emphasis added.)

[8] 42 C.F.R. § 405.1837(e)(2) specifies that "The Board *may make* ***jurisdictional findings*** *under § 405.1840* ***at any time***, including, but not limited to, following a request by the providers for the jurisdictional findings." Similarly, Board Rule 4.1 confirms that "[t]he Board may review jurisdiction on its own motion ***at any time***." (Emphasis added.)

[9] No. 20-3461, 2022 WL 888190 at *10 (D.D.C. Mar. 25, 2022). Specifically, the Court in *Memorial Hospital* states the following at 2022 WL 888190 at *10:

> Plaintiffs also contend that the PRRB's delay stymied them from pursuing relief in other ways. The hospitals were no doubt exceedingly frustrated by waiting eleven years for a resolution of their appeal, only to have it *sua sponte* dismissed by the PRRB. The Board could certainly have acted with greater alacrity, but *no matter its pace,* ***the PRRB was still obligated to determine if it had jurisdiction*** *and, if not, to "dismiss[ ] the appeal," as it did here*. See 42 C.F.R. § 405.1840(c)(2); id. at § 405.1840(a)(4). Plaintiffs argue that jurisdictional issues could have been raised earlier—such as when the PRRB acknowledged receipt of the appeal in 2009 . . . —and that they could have been allowed to brief the jurisdictional issue prior to dismissal. . . . They also note that the MAC told the PRRB when the case was initially filed that "no jurisdictional impediments exist for these providers." . . . *While the hospitals may feel sandbagged, the PRRB's rules explicitly state that "[a]n acknowledgement does not limit the Board's authority . . . to dismiss the appeal if it is later found to be jurisdictionally deficient."* CMS, PRRB Rule 9 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. And the Board's acknowledgement of receipt was purely procedural and did not address the merits of the appeal. ***The Board, moreover, is allowed to "review jurisdiction on its own motion at any time."*** CMS, PRRB Rule 4.1 (Aug. 29, 2018), https://go.cms.gov/3vEW0LW. There was thus nothing improper about its dismissing the hospitals' claims on its own motion, although it admittedly could have done so sooner.

(Underline emphasis in original and bold and italics emphasis added.)

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[10] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[11]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[12] These cases involve the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[13]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[14] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[15] The DPP is defined as the sum of two fractions expressed as percentages.[16] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> [T]he fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were entitled to benefits under part A of this subchapter . . . .[17]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[18]

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[10] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[11] *Id.*
[12] *See* 42 U.S.C. § 1395ww(d)(5).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[14] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[16] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[17] (Emphasis added.)
[18] 42 C.F.R. § 412.106(b)(2)-(3).

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> The fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were not entitled to benefits under part A of this subchapter, and the denominator of which is the total number of the hospital's patient days for such period.
>
> In determining under [this subclause] the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under subchapter XI.

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[19]

Until its recent amendment, the implementing regulation at 42 C.F.R. § 412.106(b)(4) (2022) reads, with regard to computing the Medicaid Fraction:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
>
> (i) For purposes of this computation, a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day**, regardless of whether particular items or services were covered or paid under the State plan or the authorized waiver.
>
> (ii) Effective with discharges occurring on or after January 20, 2000, for purposes of counting days under paragraph (b)(4)(i) of this section, **hospitals may include all days attributable to**

[19] 42 C.F.R. § 412.106(b)(4).

> **populations eligible for Title XIX matching payments through a waiver approved under section 1115 of the Social Security Act**.
>
> (iii) **The hospital has the <u>burden</u> of furnishing data adequate <u>to prove eligibility for each Medicaid patient day claimed</u> under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day**.[20]

B. Background on Medicaid State Plans and § 1115 Waivers

Medicaid is a joint Federal and state program, established in Title XIX of the Social Security Act (the "Act").[21] To participate in the Medicaid program and receive federal matching funds (commonly referred to as federal financial participation or "FFP"),[22] a state must enter into an agreement ("State Plan") with the Federal government, describing the individuals covered, services provided, reimbursement methodologies for providers, and other administrative activities.[23]

Federal law provides states flexibility in operating Medicaid programs through multiple waivers of federal law and demonstration programs. To address the medical needs of its residents, a State may choose to apply for, and include in its State Plan, a demonstration program under § 1115 of the Act (42 U.S.C. § 1315) which allows CMS to waive various Federal Medicaid eligibility and benefits requirements. These projects expand Medicaid eligibility to populations who would ordinarily be disqualified from receiving benefits under the State Plan. The costs of such a demonstration project, including the costs of patient treatment, are regarded as expenditures under the State Plan and thus eligible for Federal matching funds.[24]

Prior to 2000, "hospitals were to include in the Medicare DSH calculation ***only*** those days for populations *under the section 1115 waiver* who were or could have been made eligible under a State plan."[25] As a result, patient days of *expanded* eligibility groups were *not* included in the Medicare DSH calculation.

In 2000, the Secretary published an interim rule to address the DSH adjustment calculation policy in reference to § 1115 waiver days and allow for certain *expanded* eligibility groups to be included in the Medicare DSH calculation.[26] Specifically, the interim rule revised this policy "to allow hospitals to include the patient days of all populations eligible for Title XIX matching payments in a State's section 1115 waiver in calculating the hospital's Medicare DSH adjustment."[27] This

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[20] (Bold and underline emphasis added and italics in original.)
[21] 42 U.S.C. § 1396; 42 C.F.R. § 430.0.
[22] 42 U.S.C. § 1396b.
[23] 42 U.S.C. § 1396a.
[24] 42 U.S.C. § 1315(a)(2)(A).
[25] 65 Fed. Reg. 3136, 3136(Jan. 20, 2000) (emphasis added).
[26] *Id.* The interim rule was followed by a final rule, as well. 65 Fed. Reg. 47054, 47086-87 (Aug. 1, 2000).
[27] 65 Fed. Reg at 3136-3137. *See also* 65 Fed. Reg. at 47086-47087.

change in policy was effective for discharges occurring on or after January 20, 2000 and was codified in the regulations at 42 C.F.R. § 412.106(b)(4)(ii).[28]

In 2003, the Secretary amended the DSH regulation to specify that a patient shall be "deemed eligible for Medicaid on a given day only if the patient is *eligible for inpatient hospital services* under a [State Plan] or under a waiver authorized under section 1115(a)(2)."[29] The rationale was that "certain section 1115 demonstration projects . . . serve expansion populations with benefit packages so limited that the benefits are not similar to the medical assistance available under a Medicaid State plan."[30] The purpose of the refinement was to include in the Medicaid Fraction only days of waiver populations where they were provided inpatient hospital benefits equivalent to the care provided to beneficiaries under a Medicaid State Plan.[31] To achieve this, the DSH regulation at 42 C.F.R. § 412.106(b)(4)(i) was amended to specify that "a patient is deemed eligible for Medicaid on a given day **only if the patient is eligible for inpatient hospital services** under an approved State Medicaid plan or under a waiver authorized under section 1115(a)(2) of the Act on that day . . . ."[32]

In 2006, Congress passed the Deficit Reduction Act of 2005 and this legislation amended 42 U.S.C. § 1395ww(d)(5)(F)(vi)[33] by adding the following language below subclause (II):

> In determining under subclause (II) the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under title XIX, the Secretary may, to the extent and for the period the Secretary determines appropriate, include patient days of patients not so eligible but who are regarded as such because they receive benefits under a demonstration project approved under title XI.

The Secretary has interpreted this amendment as confirming that waiver day groups' days are not automatically "eligible for Medicaid under a State plan," that she has the discretion to determine the extent to which patients are "not so eligible," and to what extent, if any, they may be "regarded as eligible" and thus included in the Medicaid fraction.[34]

On August 28, 2023 as part of the FFY 2024 IPPS Final Rule, the Secretary finalized further revisions to the regulations governing the inclusion of § 1115 expansion days in the Medicare DSH calculation.[35] In making these revisions, the Secretary has noted a rise in § 1115 waiver demonstrations which authorize funding a limited and narrowly circumscribed set of payments to hospitals, such as § 1115 demonstrations which include funding for uncompensated/ undercompensated care pools. These pools do not extend health insurance to individuals or

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[28] 65 Fed. Reg. at 3139.
[29] 68 Fed. Reg. 45346, 45470 (Aug. 1, 2003).
[30] *Id.* at 45420.
[31] *See* 88 Fed. Reg. 58460, 59014 (Aug. 28, 2023).
[32] (2022) (emphasis added).
[33] Pub. L. 109-171, § 5002, 120 Stat. 4, 31 (2006).
[34] 88 Fed. Reg. at 59014.
[35] *Id.* at 59012-26.

benefits similar to Medicaid beneficiaries under a State plan. Instead, they provide funds directly to hospitals to offset treatment costs for uninsured and underinsured patients.[36] As such, these days have been typically excluded from the Medicaid fraction of the DSH calculation because the days associated with these § 1115 demonstrations do not create inpatient hospital eligibility.

The Secretary acknowledged that several court decisions have disagreed with this approach and ruled that 42 C.F.R. § 412.106(b)(4) requires the inclusion of days for which hospitals received payment from a uncompensated/undercompensated care pool authorized by a § 1115 waiver.[37] Thus, in the FFY 2022 IPPS/LTCH PPS proposed rule,[38] the Secretary proposed to revise the regulation "to more clearly state that in order for an inpatient day to be counted in the DPP Medicaid fraction numerator, the section 1115 demonstration must provide inpatient hospital insurance benefits directly to the individual whose day is being considered for inclusion."[39] After reviewing comments on the proposal, the Secretary proposed different revisions to the regulations in the FFY 2023 IPPS/LTCH PPS proposed rule,[40] but opted not to finalize them after reviewing comments on the proposal.[41]

Finally, in a proposed rule published on February 28, 2023,[42] the Secretary proposed revisions to the regulations "on the counting of days associated with individuals eligible for certain benefits provided by section 1115 demonstrations[.]"[43] Thereafter in the FFY 2024 IPPS Final Rule, he announced that "we are modifying our regulations to explicitly state our long-held view that only patients who receive health insurance through a section 1115 demonstration where State expenditures to provide the insurance may be matched with funds from title XIX can be 'regarded as' eligible for Medicaid."[44] He also finalized a proposed amendment "to state specifically that patients whose inpatient hospital costs are paid for with funds from an uncompensated/undercompensated care pool authorized by a section 1115 demonstration are not patients "regarded as" eligible for Medicaid, and the days of such patients may not be included in the DPP Medicaid fraction numerator."[45]

Thus, effective October 1, 2023, 42 C.F.R. § 412.106(b)(4) (2023) now reads:

> (4) *Second computation*. The fiscal intermediary determines, for the same cost reporting period used for the first computation, the number of the hospital's patient days of service for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days as described in paragraph (b)(4)(i) of this section or who were regarded as eligible for Medicaid on such days

[36] *Id.* at 59015.
[37] *Id.* (citing *Bethesda Health, Inc.* v. *Azar*, 980 F.3d 121 (D.C. Cir. 2020); *Forrest General Hospital* v. *Azar*, 926 F.3d 221 (5th Cir. 2019); *HealthAlliance Hospitals, Inc.* v. *Azar*, 346 F. Supp. 3d 43 (D.D.C. 2018)).
[38] 86 Fed. Reg. 25070 (May 10, 2021).
[39] *Id.* at 25459.
[40] 87 Fed. Reg. 28108 (May 10, 2022).
[41] 87 Fed. Reg. 48780, 49051 (Aug. 10, 2022).
[42] 88 Fed. Reg. 12623 (Feb. 28, 2023).
[43] *Id.* at 12623.
[44] 88 Fed. Reg. at 59016.
[45] *Id.*

> and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total number of patient days in the same period. For purposes of this second computation, the following requirements apply:
> (i) For purposes of this computation, a patient is eligible for Medicaid on a given day if the patient is eligible on that day for inpatient hospital services under a State Medicaid plan approved under title XIX of the Act, regardless of whether particular items or services were covered or paid for on that day under the State plan.
>
> (ii) For purposes of this computation, a patient is regarded as eligible for Medicaid on a given day if the patient receives health insurance authorized by a demonstration approved by the Secretary under section 1115(a)(2) of the Act for that day, where the cost of such health insurance may be counted as expenditures under section 1903 of the Act, or the patient has health insurance for that day purchased using premium assistance received through a demonstration approved by the Secretary under section 1115(a)(2) of the Act, where the cost of the premium assistance may be counted as expenditures under section 1903 of the Act, and in either case regardless of whether particular items or services were covered or paid for on that day by the health insurance. Of these patients regarded as eligible for Medicaid on a given day, only the days of patients meeting the following criteria on that day may be counted in this second computation:
>
> > (A) Patients who are provided by a demonstration authorized under section 1115(a)(2) of the Act health insurance that covers inpatient hospital services; or
> >
> > (B) Patients who purchase health insurance that covers inpatient hospital services using premium assistance provided by a demonstration authorized under section 1115(a)(2) of the Act and the premium assistance accounts for 100 percent of the premium cost to the patient.
>
> (iii) Patients whose health care costs, including inpatient hospital services costs, for a given day are claimed for payment by a provider from an uncompensated, undercompensated, or other type of funding pool authorized under section 1115(a) of the Act to fund providers' uncompensated care costs are not regarded as eligible for Medicaid for purposes of paragraph (b)(4)(ii) of this section on that day and the days of such patients may not be included in this second computation.[46]

[46] *Id.* at 59332.

Decision of the Board:

Pursuant to 42 C.F.R. § 405.1837(a)(1), a group of providers generally have the right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[47] if each provider satisfies individuals the requirements for a Board hearing under § 405.1835(a) and the group's amount in controversy is $50,000 or more. Pursuant to 42 C.F.R. § 405.1835(a)(1), an individual provider generally has a right to a hearing before the Board "with respect to a final contractor or Secretary determination ***for the provider's cost reporting period***"[48] if:

- It "is dissatisfied *with the contractor's final determination of the total amount of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803"[49] In other words, providers must appeal from a "final determination" that impacts payment for the period under appeal.[50]

- The request for a hearing is filed within 180 days of the date of receipt of the final determination.[51]

42 C.F.R. § 405.1837(c)(1) specifically notes that the hearing request must include "[a] demonstration that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) [which includes the requirements of 42 C.F.R .§ 405.1835(a)]." Section 405.1835(a) states, in pertinent part, that a provider has a right to a Board hearing:

> [W]ith respect to a final … determination ***for the provider's cost reporting period***, if – (1) The provider is dissatisfied with the contractor's final *determination* of total amount *of reimbursement* ***due the provider***, as set forth in the contractor's written notice specified under § 405.1803.[52]

42 C.F.R. § 405.1801(a) defines the term "contractor determination" as including:

> (2) With respect to a hospital that receives payments for inpatient hospital services under the prospective payment system (part 412

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[47] (Emphasis added).
[48] 42 C.F.R. § 405.1835(a) (emphasis added).
[49] 42 C.F.R. § 405.1835(a)(1) (emphasis added).
[50] *See also* 42 U.S.C. § 1395oo(a)(1)(A); *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-146 (D.C. Cir. 1986) (stating: "Viewing the amendments as a whole, we are inescapably drawn to the same conclusion as the District Court: § 1395oo (a) 'clearly contemplates two different kinds of appeal. One begins when the intermediary issues an NPR; the other, when the intermediary issues a notice of ***what will be paid*** *under the PPS system*.' . . . . Under PPS, in contrast, ***payment amounts*** are independent of current costs and *can be determined with finality* prior to the beginning of the cost year. Id. § 412.71(d). Thus a year-end cost report is not a report which is necessary ***in order for the Secretary to make PPS payments***, and the appeals provision applicable to PPS recipients cannot be read to require hospitals to file cost reports and await NPRs prior to filing a PRRB appeal." (emphasis added and citations omitted)).
[51] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[52] (Emphasis added.)

> of this chapter), the term means a final determination of the total amount of payment due the hospital, pursuant to § 405.1803 following the close of the hospital's cost reporting period, under that system for the period covered by the final determination.
>
> (3) For purposes of appeal to the Provider Reimbursement Review Board, the term is synonymous with the phrases "intermediary's final determination," "final determination of the organization serving as its fiscal intermediary," "Secretary's final determination" and "final determination of the Secretary," as those phrases are used in section 1878(a) of the Act, and with the phrases "final contractor determination" and "final Secretary determination" as those phrases are used in this subpart.

Similarly, Paragraph (c)(2) of 42 C.F.R. § 405.1837 requires certain information relative to each specific item under appeal with respect to the final determination under appeal:

> (2) An explanation (for each specific item at issue) of each provider's dissatisfaction with the final contractor or Secretary determination under appeal, including an account of:
>
> (i) *Why the provider believes Medicare* ***payment*** *is incorrect for each disputed item*;
>
> (ii) How and why the provider believes Medicare payment must be determined differently for each disputed item; and
>
> (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.

42 C.F.R. § 405.1837(a)(3) also states that a group must demonstrate that the amount in controversy is $50,000 or more. Satisfying the criteria set out in 42 C.F.R. §§ 405.1835(a) and 1837(a) is required before the Board can exercise jurisdiction over an appeal.[53]

The Providers are appealing the Final Rule published on August 28, 2023 pursuant to 42 U.S.C. § 1395oo(a)(1)(A)(i), which allows for a hearing before the Board if a provider:

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[53] 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. However, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. § 405.1835(b) addresses claim filing requirements.

> [I]s dissatisfied **with a final determination *of the organization serving as its fiscal intermediary*** pursuant to section 1395h of this title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such report.[54]

The Board notes that the purported "final determination" being appealed in each case is a policy codified in regulation as part of a final rule published in the Federal Register. Significantly, the purported "final determination was not issued by the Providers' Medicare administrative contractor (formerly known as "fiscal intermediary") but rather was issued by the Secretary.

The Board notes that the alleged "final determination" being appealed in each case is a change in policy adopted in a final rule published in the Federal Register, namely the FFY 2024 IPPS Final Rule. However, the adoption and codification of this policy in the FFY 2024 IPPS Final Rule is not a "final determination" *directly appealable to the Board under 42 U.S.C. § 1395oo(a)(1)(A)(i) or (ii)*. Rather, the Providers' appeals of the group issue are premature.

Here, unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) is not *prospectively* set on an annual basis as part of the relevant IPPS final rule. Rather, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period."[55] To this end, DSH eligibility and payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) Interim [DSH] payments are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
>
> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[56]

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[54] (Emphasis added.)
[55] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.
[56] (Italics emphasis in original and bold and underline emphasis added.)

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[57]
Indeed, a hospital that is potentially eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e.*, subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report (where final payment is determined and reimbursed through the cost

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[57] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FFY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

report audit and settlement process) include bad debts,[58] direct graduate medical education ("GME"),[59] and indirect GME.[60] This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ."[61] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[62]

To highlight what types of determinations are being made during the cost report audit/settlement process, the Board notes that any potential § 1115 waiver days for the fiscal years at issue would be included in the numerator of the Medicaid fraction used in each Provider's DSH adjustment calculation for each of the relevant fiscal years; however, in order for a day to be included in the numerator of the Medicaid fraction, 42 C.F.R. § 412.106(b)(4) (Oct. 1, 2023) specifies that the Medicare contractor (a/k/a fiscal intermediary[63]) "*determines*" the days to be included in the numerator of a hospital's Medicaid fraction based on the hospital's "burden" of "prov[ing]" Medicaid eligibility *on* ***each*** *day being claimed* ***on the cost report*** for the relevant fiscal year:

> (4) *Second computation*. **The fiscal intermediary determines**, for the same cost reporting period used for the first computation, **the number of the hospital's patient days** of service **for patients who were not entitled to Medicare Part A, and who were either eligible for Medicaid on such days** as described in paragraph (b)(4)(i) of this section **or who were regarded as eligible for Medicaid on such days** and the Secretary has determined to include those days in this computation as described in paragraph (b)(4)(ii)(A) or (B) of this section. The fiscal intermediary then divides that number by the total

[58] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).
[59] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§ 413.75–413.83 of this chapter.").
[60] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).
[61] 795 F.2d at 143 (emphasis added).
[62] *Id.* at 147 (footnote omitted).
[63] CMS' payment and audit functions under the Medicare program were historically contracted to organizations known as fiscal intermediaries ("FIs") and these same functions are now contracted with organizations known as Medicare administrative contractors ("MACs"). The term "Medicare contractor" refers to both FIs and MACs.

> number of patient days in the same period. For purposes of this second computation, the following requirements apply:
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> (iv) **The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed** under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.[64]

Accordingly, unlike DRG rates and wage index rates, a hospital's eligibility for a DSH payment (and, if so, the amount) is determined through the following *italicized* phrase in 42 U.S.C. § 1395oo(a) and, as such, is a prerequisite to the Providers' appeal:

> (a) . . . any hospital which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports* within such time as the Secretary may require *in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider—
>
> (A)(i) is dissatisfied with a final determination of the organization serving as its fiscal intermediary pursuant to section 1395h of this

[64] 88 Fed. Reg. at 59332; 42 C.F.R. § 412.106 (Oct. 1, 2023). *See also id.* at 59023 (stating: "We are unsure why some commenters have significant concerns with verifying an individual's section 1115 eligibility and the amount of premium assistance when hospitals are already communicating with their state Medicaid office to verify an individual's eligibility. We do not understand why it is unclear who would furnish this data to hospitals or how hospitals would obtain the patient-specific data that they would need to prove eligibility for each patient under the proposed premium assistance rule. The states have this information as part of the section 1115 demonstration requirements. Finally, as a commenter recognizes, *it **remains the hospitals' burden** to furnish data adequate **to prove eligibility for each Medicaid patient day it claims** in the DPP Medicaid fraction numerator*, and we believe that the state will continue to be able to furnish hospitals with the eligibility data necessary for the hospitals to do so." (emphasis added)); 63 Fed. Reg. 40954, 40985 (Jul. 31, 1998) (revising 42 C.F.R. § 412.106 to codify HCFA Ruling 97-2); HCFA Ruling 97-2 at 4 (Feb. 1997) (stating: "Pursuant to this Ruling, Medicare fiscal *intermediaries will **determine*** the amounts due and make appropriate payments through normal procedures. Claims must, of course, meet all other applicable requirements. This includes the requirement for data that are adequate to document the claimed days. ***The hospitals bear the burden of proof** and must verify with the State that a patient was eligible for Medicaid* (for some covered services) *during **each** day of the patient's inpatient hospital stay*. As the intermediaries may require, hospitals are responsible for and must furnish appropriate documentation to substantiate the number of patient days claimed. *Days for patients that can**not** be verified by State records* to have fallen within a period wherein the patient was eligible for Medicaid *can**not** be counted*." (emphasis added)); 80 Fed. Reg. 70298, 70559 (Nov. 13, 2015) ("We have identified only *one circumstance where a provider may have difficulty obtaining sufficient information to make an appropriate cost report claim within the allotted time **for cost report submission***. This circumstance may occur if a hospital experiences difficulty obtaining sufficient information from State agencies *for the purpose of **claiming** DSH Medicaid-eligible patient days*. Therefore, as explained below in our response to the next comment, we will instruct contractors, in this limited circumstance, that they must accept one amended cost report submitted within a 12-month period after the hospital's cost report due date, solely for the specific purpose of revising a claim for DSH by using updated Medicaid-eligible patient days, after a hospital receives updated Medicaid eligibility information from the State." (emphasis added)).

> title as to the amount of total program reimbursement due the provider for the items and services furnished to individuals for which payment may be made under this subchapter for the period covered by such [cost] report, or
>
> (ii) is dissatisfied with a final determination of the Secretary as to the amount of the payment under subsection (b) or (d) of section 1395ww of this title, . . .

Specifically, a hospital that is eligible for a DSH payment must "submit[] such [cost] report[] within such time as the Secretary may require *in order to make payment under such section* [*i.e*., subsection (d)]" as confirmed in the above quote of 42 C.F.R. § 412.106(i). This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decision in *Washington Hospital*[65] and *Cape Cod Hospital v. Sebelius*.[66]

The Board recognizes that, in the 2022 *Memorial Hospital* and 2023 *Battle Creek* decision, the D.C. District Court addressed the Board's jurisdiction over appeals based on the publication of the SSI fractions[67] (another variable used in the DSH calculation) and reached different conclusions. In the instant case, the Board declines to follow D.C. District Court's 2023 decision in *Battle Creek* and

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[65] The type of situation presented in the above-captioned cases is unlike the type of situation addressed by the D.C. Circuit in *Washington Hosp.* where the determination that was appealed finalized the ***only*** hospital-specific variable used in setting the per-patient payment amount. *See Washington Hosp.*, 795 F.2d at 143, 147 (the hospitals appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the Court found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ." (emphasis added); and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB." (footnote omitted)).

[66] 630 F.3d 203, 209 (D.C. Cir. 2011).

[67] The Board also recognizes that the publication of the SSI ratios was at issue in *Allina Health Servs. v. Price*, 863 F.3d 937, 940–43 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*"). However, *Allina II* has no relevance to the ***jurisdictional*** issue being addressed here. First, the *Allina II* litigation does *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*e.g*., it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*). Further, the Board takes administrative notice that the Complaint filed to establish the *Allina II* litigation makes clear that ***none*** of the nine (9) Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the nine (9) Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo****(a)(1)(B)***42 as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: "38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)). Accordingly, it is clear that the *Allina II* litigation has no relevance to the ***jurisdictional*** question addressed by the Board in the instant case, namely whether the Providers have the right to appeal the policy at issue published in the FFY 2024 IPPS Final Rule pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***.

instead finds the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.[68] While the D.C. District Court's 2022 decision in *Memorial Hospital* also concerns the publication of SSI fractions, the Board finds it instructive based on its thoughtful application of the D.C. Circuit's decision in *Washington Hospital*. The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the Court distinguished these cases because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[69] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the Court agreed with the Secretary that the publication of the SSI ratios, *even if final*, could not be a final determination "as to the amount of payment" because they are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[70] The Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[71]

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[68] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss (much less reference) the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Further, the Board notes that the Secretary's handling of the Part C days policy change announced in the June 9, 2023 Final Rule (88 Fed. Reg. 37772 (June 9, 2023)) supports the Board's findings here as that final rule *only* discussed hospital appeal rights from an NPR or RNPR to be issued following the publication of revised SSI fractions. Specifically, in finalizing that the recent Part C days policy adoption in the June 2023 Final Rule, the Secretary announced that "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically." 88 Fed. Reg. at 37788 (emphasis added).

[69] 2022 WL 888190 at *8.

[70] *Id.* at *9 (emphasis added).

[71] *Id.* at *8.

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[72]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was promulgated as part of the FFY 2024 IPPS Final Rule, it is ***not*** a final determination as to the amount of payment received by the Providers but rather is "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*" and any "***final*** *payment* determination"[73] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i).[74] More specifically, here, each of the Providers are asserting that certain unspecified § 1115 waiver days[75] must be included in the numerator of the Medicaid fraction for their DSH adjustment calculation *yet-to-be calculated* for the fiscal years at issue. As such, the Providers' appeal is premature.

Indeed, while the August 28, 2023 Final Rule being appealed in the instant appeals was clearly promulgated as a final rule, it is ***not*** *the* ***only*** *determination or variable on which the Provider's DSH payment depends*. Just like the publication of SSI ratios, the policy at issue impacts one of many variables in calculating the Provider's DSH payment and is thus not an appealable final determination. More specifically, here, each of the Providers are asserting that certain § 1115 waiver days must be included in the Medicaid fraction for their DSH adjustment calculation for their 2024 fiscal year. However, consistent with 42 C.F.R. § 412.106(i) and the cost report audit/settlement process, the following factual gaps or flaws demonstrate that the promulgation of the policy at issue in the FFY 2024 IPPS Final rule was ***not*** an appealable reimbursement "determination":

1. The FFY 2024 IPPS Final Rule does not apply the newly-promulgated § 1115 waiver day policy to ***specific*** existing State Medicaid programs which have § 1115 waiver programs that are otherwise covered by the "bar" described in the group issue statements. The Board recognizes that the Providers in these appeals have identified a specific § 1115 waiver program for each appeal, based on the state to which they operate. However, the FFY 2024 IPPS Final Rule does not apply the new policy to a specific § 1115 waiver program(s), presumably because § 1115 waiver programs are ***not*** necessarily *static* ***and*** *may potentially*

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[72] *Id.* at *9. While the Providers' did not reference the D.C. Circuit's decision in *Mercy Hospital, Inc. v. Azar*, 891 F.3d 1062, 1067 (D.C. Cir. 2018) ("*Mercy*"), the Board notes that the *Mercy* decision is not applicable for 2 separate reasons. First, it does not address the DSH payment calculation *under IPPS for short term acute care hospitals*, but rather addresses the low-income payment ("LIP") for inpatient rehabilitation hospitals ("IRFs"). Second, it does not address the scope of the provider's right to appeal *under 42 U.S.C. § 1395oo(a)* but rather concerns substantive jurisdiction, *i.e.*, whether a specific statute enacted by Congress precludes the Board from conducting administrative review of the LIP issue appealed by the IRF in *Mercy*, regardless of how the provider appealed (*i.e.*, regardless of whether the appeal was based on a cost report, NPR or final rule).

[73] 42 C.F.R. § 412.106(i)(2) (emphasis added).

[74] 2022 WL 888190 at *9 (emphasis added).

[75] Since the periods appealed have not fully transpired or, in some cases even begun, when this appeal was filed (*see supra* note 3), the Providers had no ability to identify the specific § 1115 waiver days, if any, that would occur during those periods consistent with their burden of proof under 42 C.F.R. § 412.106(b)(4)(iii).

change from one year to next year. How the new policy may apply to a *particular* state § 1115 waiver program ***for a particular year*** is a factual dispute that would need to be determined by the Medicare Contractor as it relates to days *yet-to-be* identified and claimed on *yet-to-be* filed cost reports for the fiscal years at issue as part of the cost report audit and settlement process specified in 42 C.F.R. §§ 412.106(b)(4) and 412.106(i).[76]

2. It is unclear whether any of the Providers in these groups will, ***in fact***, qualify for a DSH payment during their fiscal year 2024 as that is not determined in the FFY 2024 Final Rule. Rather, that is a case-by-case determination made after the cost report is filed.[77]

3. Even if the Providers were to qualify for a DSH payment in their FYs 2023, 2024, and/or 2025 as relevant,[78] it is not clear that *any* of the Providers would have patients during these fiscal years that are, in fact, covered under a § 1115 waiver program, much less "an uncompensated care pool" that would be barred from being counted in the DSH calculations under the new § 1115 waiver day policy. The Providers have included amounts in controversy but it is unclear what those estimates are based on since these are prospective estimates of anticipated § 1115 uncompensated care pool days occurring on or after October 1, 2024 that would be covered by the alleged "bar." Indeed, § 1115 waiver days are one type of Medicaid eligible day and 42 C.F.R. § 412.106(b)(4)(iii) specifies that "[t]he hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day." None of the Providers has met this burden of proof *relative to the fiscal years at issue* because ***none*** of the days that could or would be at issue were known/provided when the alleged determination (*i.e*., the FFY 2024 IPPS Final Rule) was issued.

4. To the extent any § 1115 waiver days are included in the numerator of the Medicaid fraction for a hospital that is eligible for a DSH payment, the § 1115 waiver days would be just one category of Medicaid eligible days that would be included in the numerator and the Medicare Contractor must review/audit any days claimed on the as-field cost report to confirm Medicaid eligible on each day claimed because, per 42 C.F.R. § 412.106(b)(4), the hospital has the burden of proof to establish Medicaid eligibility for each day claimed.

5. The SSI percentage is a variable used in calculating a provider's DSH adjustment payment; however, CMS has not yet published the SSI ratios that would be used in the Providers' FY 2023, 2024, and 2025 as relevant[79] *if each of these Providers were to qualify for a DSH payment in those fiscal years where the SSI percentage is just one factor in making that determination*.

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[76] Indeed, there is no case law applying 42 C.F.R. § 412.106(b)(4) to the current Texas § 1115 waiver program or any of the other programs listed in the appeal requests.
[77] The fact that the Providers qualified in prior years does not mean that they will in fact qualify for future years where the future years may be FYs 2023, 2024, and/or 2025, as relevant in relation to FFY 2024 (*see supra* note 3).
[78] *See supra* note 3.
[79] *See supra* note 3.

As discussed above, the Board finds that the August 28, 2023 Final Rule appealed in the instant cases is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835. Since satisfying the criteria set out in 42 C.F.R. § 405.1835 is required before the Board can exercise jurisdiction over an appeal,[80] and since the Providers have failed to demonstrate in their hearing requests that those criteria have been met for the fiscal years under appeal (*i.e*., their FYs 2023, 2024 and/or 2025, as relevant in relation to FFY 2024[81]), the Board is permitted under § 405.1835(b) to "dismiss with prejudice the appeal or take any other remedial action it considers appropriate."[82] In this instance, the Board finds it is appropriate to dismiss the appeals as premature[83] and remove them from the Board's docket based on its findings that the promulgation of the § 1115 waiver day policy in the August 28, 2023 Final Rule is not an appealable final determination.

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

Board Members Participating:

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

For the Board:

3/11/2024

X Clayton J. Nix

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

cc: Cecille Huggins, Palmetto GBA (J-J)
Byron Lamprecht, WPS, (J-5)
Geoff Pike, First Coast Services Option, Inc., (J-N)
Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Wilson Leong, FSS
Jacqueline Vaughn, OAA

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[80] 42 C.F.R. § 405.1840(a), (b).

[81] *See supra* note 3.

[82] 42 C.F.R. § 405.1835(b). *See also* 42 C.F.R. § 405.1837(a)(1), (c)(1), (c)(3). The Board's position is supported also by *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986) ("*Washington Hospital*") because in that case the final rule contained "the only variable factor . . . as to the amount of payment under § 1395ww(d) . . . [,] the hospital's target amount, which the Secretary refers to as the hospital-specific rate." Unlike *Washington Hospital*, the policy on § 1115 waiver days is just one factor involved in determining the amount of a DSH payment for a particular year which is only calculated (i.e., relevant) if a hospital qualifies for DSH for that year. *See Memorial Hospital v. Becerra*, 2022 WL 888190 at *7-8 (D.D.C. 2022).

[83] The Providers are not prejudiced by the Board's dismissal because, to the extent the § 1115 waiver day policy promulgated in the FFY 2024 IPPS Final Rule is, in fact, applicable to them for their FYs 2023, 2024 and/or 2025 as relevant (*see supra* note 3), the Providers will have an opportunity to appeal the NPR for those fiscal years once it is issued (or appeal the non-issuance of that NPR is if it is not timely issued per 42 C.F.R. § 405.1835(c)).

ATTACHMENT A
List of Group Appeals

24-1531GC	HCA FFY 2024 § 1115 Waiver Days Tennessee CIRP Grp	Palmetto GBA (J-J)
24-1540GC	HCA FFY 2024 § 1115 Waiver Days Kansas CIRP Group	WPS Government Health Adm'rs ("WPS") (J-5)
24-1543GC	HCA FFY 2024 § 1115 Waiver Days Florida CIRP Group	WPS (J-5)
24-1557GC	Cleveland Clinic Fdn. FFY 2024 § 1115 Waiver Days Florida CIRP Group	First Coast Service Options, Inc. ("First Coast") (J-N)
24-1558GC	Broward Health FFY 2024 § 1115 Waiver Days FL CIRP Grp	First Coast (J-N)
24-1559GC	Ballad Health FFY 2024 § 1115 Waiver Days TN CIRP Grp	Palmetto GBA (J-J)
24-1560GC	Baptist Mem'l FFY 2024 § 1115 Waiver Days TN CIRP Grp	Palmetto GBA (J-J)
24-1561GC	Covenant Health (TN) FFY 2024 § 1115 Waiver Days TN CIRP	Palmetto GBA (J-J)
24-1564GC	Univ of KS Health Sys FFY 2024 § 1115 Waiver Days KS CIRP	WPS (J-5)
24-1571GC	Orlando Health FFY 2024 § 1115 Waiver Days FL CIRP Group	First Coast (J-N)
24-1574GC	TGH Health FFY 2024 § 1115 Waiver Days Florida CIRP Group	WPS (J-5)
24-1581GC	Ascension Health FFY 2024 § 1115 Waiver Days TN CIRP Grp.	Palmetto GBA (J-J)
24-1582GC	UHS FFY 2024 § 1115 Waiver Days Florida CIRP Group	Novitas Solutions, Inc. (J-L)
24-1583GC	Ascension Health FFY 2024 § 1115 Waiver Days KS CIRP Grp	WPS (J-5)
24-1584GC	Mem'l Healthcare FFY 2024 § 1115 Waiver Days FL CIRP Grp	First Coast (J-N)
24-1585GC	Ascension Health FFY 2024 § 1115 Waiver Days FL CIRP Grp	First Coast (J-N)
24-1586GC	CHS FFY 2024 § 1115 Waiver Days Tennessee CIRP Group	Palmetto GBA (J-J)
24-1587GC	CHS FFY 2024 § 1115 Waiver Days Florida CIRP Group	WPS (J-5)
24-1589GC	Baptist Health South FL FFY 2024 § 1115 Waiver Days FL CIRP	First Coast (J-N)
24-1591GC	BS&W Health FFY 2024 § 1115 Waiver Days Texas CIRP Group	Novitas Solutions, Inc. (J-H)
24-1593G	King & Spalding FFY 2024 § 1115 Waiver Days Florida Group	First Coast (J-N)
24-1595G	King & Spalding FFY 2024 § 1115 Waiver Days Texas III Group	Novitas Solutions, Inc. (J-H)
24-1652GC	Baptist Health Sys. FFY 2024 § 1115 Waiver Days FL CIRP Grp	First Coast (J-N)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Shannon Telliano
Sutter Health
455 Plumas Blvd.
Yuba City, CA 95949

RE: ***Notice of Dismissal***
Sutter Surgical Hospital – North Valley (Prov. No. 05-0766)
Case No. 21-0325

Dear Ms. Telliano:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Sutter Surgical Hospital's ("Provider") Individual Appeal Request on December 4, 2020.

Based on the lack of response from the Provider's Representative to the Board inquires as well as the lack of any activity or filings by the Provider since July 2021 (when the Provider filed its PPP), the Board has reason to believe the appeal has been abandoned and hereby formally orders the Provider's Representative file, ***by no later than Monday, March 11, 2024,*** a status update on the case and to *specifically advise* whether the Provider is still pursuing this appeal

On March 6, 2024, the Board issued a Notice of Potential Dismissal the Provider ordering that the Provider's Representative respond by Monday, March 11, 2024 with a status update on the case and to specifically advise whether the Provider is still pursuing this appeal. The Board detailed in its March 6, 2024 Notice that the Order was being issued based on the lack of response from the Provider's Representative to the Board inquires as well as the lack of any activity or filings by the Provider since July 2021 (when the Provider filed its preliminary position paper). The March 6, 2024 Notice specifically stated that "failure to submit a timely response to this request will result in dismissal of the case." As of the date of this letter, no response has been submitted by the Provider's representative even though the filing deadline has passed.

Pursuant to 42 C.F.R. § 405.1868:

> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may –
>
> (1) Dismiss the appeal with prejudice;
> (2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate. [1]

Having issued an Order requiring the Provider's representative to advise whether it is still pursuing the appeal *and receiving no response*, it is clear that the Provider has abandoned this case. Accordingly, the Board hereby dismisses this case and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/12/2024

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services
Lorriane Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Blvd.
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Via Electronic Delivery

Ronald Connelly, Esq.
Powers, Pyles, Sutter and Verville, P.C.
1501 M. St. NW, 7th Fl.
Washington, DC 20005

RE: ***Notice of Dismissal of Part C Appeals Based on June 9, 2023 Final Rule***
Case No. 24-0413GC, *et al.* (*see* **Appendix A** listing 15 cases)

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the fifteen (15) above-referenced common issue related party ("CIRP") group and individual cases. Set forth below is the decision of the Board to dismiss these fifteen (15) appeals challenging the treatment of Medicare Part C Days in the disproportionate share hospital ("DSH") adjustment calculation from the final rule published on June 9, 2023 entitled "Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage" (hereinafter the "June 2023 Final Rule").[1]

Background

Powers, Pyles, Sutter and Verville, P.C. ("Powers Pyles") represents a number of Providers in CIRP groups and individual cases which are challenging the treatment of Medicare Part C Days in the DSH adjustment calculation as appealed from the June 2023 Final Rule. On December 6, 2023, Powers Pyles initiated these appeals by filing appeal requests on behalf of 15 different CIRP groups and individual providers concerning the June 2023 Final Rule that the Secretary of Health and Human Services ("Secretary") published as it relates to the those providers' FY 2007-2023 Medicare disproportionate share hospital ("DSH") adjustment calculation and attached to these appeal requests a PDF copy of that Final Rule labeled as "Final Determination Document."[2]

In the June 2023 Final Rule, the Secretary adopted and finalized *its policy* to include Part C days in the SSI fraction as used in the DSH adjustment calculation for Part C discharges occurring *prior to* October 1, 2013 and applied this policy *retroactively* to certain open fiscal years to which this policy would appeal.

The Providers in the group and individual appeals all involve fiscal years ranging from 2004 to 2014. The ***sole*** issue in each of these appeals is "whether [CMS's] retroactive rule – [the June 2023 Final Rule] – and corresponding supplementary security income ("SSI") ratios published

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *Id.*

under the Final Rule, which addresses the treatment of inpatient days attributable to patients enrolled in Medicare Part C plans for purposes of calculating hospitals' disproportionate share hospital ("DSH") payment adjustments for discharges occurring before October 1, 2013, are substantively and/or procedurally invalid."[3] Thus, Powers Pyles Providers challenge the procedural and substantive validity of the policy adopted and finalized in the June 2023 Final Rule.[4] To that end, the appeal requests identify the June 2023 Final Rule as the "final determination" being appealed and also included a PDF copy of that Final Rule with the label "Final Determination Document." *Significantly,* ***none of the appeals*** *included a copy of alleged "corresponding SSI ratios applicable to the Providers, published on CMS's website on or around October 15, 2023, to implement the Final Rule*."[5]

The Providers' appeal requests have not provided ***any*** explanation in their appeal requests of why the Board has jurisdiction over their appeal of the June 2023 Final Rule and *none has specifically demonstrated that the Final Rule is,* ***in fact, applicable to them***. In this regard, the appeal requests do not include ***any*** *NPR or revised NPR in their appeal requests* (to document their eligibility for a DSH adjustment for the relevant fiscal year) or documentation of any CMS Ruling 1739-R remands from prior appeals of the DSH Part C days issue for the same year. As explained below, it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

Issue in Dispute

Powers Pyles is the group representative for these 15 cases filed on December 6, 2023. Each case has the same issue statement, which states the issue is:

> **Brief Description of Issue**: Whether the [CMS's] retroactive rule – Medicare Program: Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage, 88 Fed. Reg. 37,772 (June 9, 2023) ("Final Rule") – and corresponding supplementary security income ("SSI") ratios published under the Final Rule, which addresses the treatment of inpatient days attributable to patients enrolled in Medicare Part C plans for purposes of calculating hospitals' disproportionate share hospital ("DSH") payment adjustments for discharges occurring before October 1, 2013, are substantively and/or procedurally invalid.[6]
>
> **Statement of Legal Basis for Appeal**: The Providers challenge CMS's Final Rule addressing the treatment of inpatient days

[3] Issue Statement at 1 in Case No. 24-0413GC. Each of the Issue Statements in the 15 Powers Pyles appeals referenced in this decision are materially identical.
[4] 88 Fed. Reg. 37772 (June 9, 2023).
[5] Issue Statement at 1 in Case No. 24-0413GC (emphasis added). Each of the Issue Statements in the 15 Powers Pyles appeals referenced in this decision are materially identical.
[6] *Id.*

attributable to patients enrolled in Medicare Part C plans for purposes of calculating hospitals' DSH payment adjustments for discharges occurring before October 1, 2013. The Providers also challenge the corresponding SSI ratios applicable to the Providers, published on CMS's website on or around October 15, 2023, to implement the Final Rule. Both the Final Rule and the SSI fractions constitute "final determinations" that are appealable under 42 U.S.C. § 1395oo(a)(1)(A)(ii). *See also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 145 (D.C. Cir. 1986); *Battle Creek Health Sys. v. Becerra*, No. CV 17-0545 (CKK), 2023 WL 7156125, at *5-*6 (D.D.C. Oct. 31, 2023).

****

On June 3, 2019, the Supreme Court issued a 7-1 decision affirming the D.C. Circuit's decision. *Azar v. Allina Health Services*, 139 S. Ct. 1804, 204 (L.Ed. 139 (2019). The Supreme Court determined that the Medicare statute's notice-and-comment requirements, which require Department of Health and Human Services ("HHS") to provide public notice and a 60-day comment period for any rule, requirement, or other statement of policy that establishes or changes a "substantive legal standard" governing Medicare payment for services (42 U.S.C. § 1395hh(a)(2)), are more expansive than the APA's requirements.

Subsequently, on June 9, 2023, CMS published the Final Rule, purportedly to address the Supreme Court's decision. Instead, the Final Rule flouts the Supreme Court's decision by including inpatient days attributable to patients enrolled in Medicare Part C plans in the numerator and denominator used to calculate the SSI ratio and excluding such days attributable to Medicaid-eligible patients from the numerator of the Medicaid percentage for all cost reporting periods before October 1, 2013. In addition, on or around October 15, 2023, CMS published the SSI ratios for the Providers to implement the Final Rule. None of the SSI percentages for any of the hospitals changed from those previously published by CMS, which clearly demonstrates that Part C inpatient days are included in the SSI ratio. As further indication that Part C days are included in the SSI ratio, the webpage lists the SSI percentages under the heading "CMS 1739-F SSI Ratios", which is the identifier for the Final Rule. 88 Fed. Reg. at 37,772.

The Providers contend that the Final Rule (and corresponding SSI ratios) are procedurally and substantively invalid under the Medicare statute and the APA. The Final Rule adopts the *same* policy that the Supreme Court struck down as procedurally improper. CMS's attempt to circumvent the Supreme Court's decision establishes a concerning

> precedent. In effect, CMS seeks to avoid the consequences of violating the Medicare statute's notice-and-comment rulemaking requirements by adopting a retroactive rule that reinstates its invalidated rule. Such use of retroactive rulemaking contravenes the purpose of the Medicare statute's procedural requirements.
>
> The Final Rule and corresponding SSI ratios are arbitrary and capricious, not in accordance with law, and/or procedurally invalid. See 5 U.S.C. § 706(2)(A), (C) (D). CMS lacks the authority to apply the Final Rule retroactively. Section 1871 of the Social Security Act permits CMS to engage in retroactive rulemaking only if the Secretary determines that such retroactive application is necessary to comply with statutory requirements or that failure to apply the policy retroactively would be contrary to the public interest. 42 U.S.C. § 1395hh(e)(1)(A)(i). CMS has failed to satisfy either of these conditions and, therefore, is statutorily prohibited from retroactively implementing the Final Rule or publishing SSI ratios to implement the Final Rule.
>
> CMS asserts in the Final Rule that retroactive rulemaking is required in order to comply with the Medicare statute's requirement regarding the calculation of Medicare DSH payments before FY 2014. However, as described above, CMS's policy excluding Part C days from the Medicaid percentage and including Part C days in the Medicare/SSI percentage violates the plain wording of the Medicare statute. In addition, CMS took the position that it is in the public interest for CMS to implement the Final Rule for the "hundreds of hospitals whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports." But there is no reason that CMS cannot settle the thousands of cost reports by excluding Medicare Part C days from the SSI ratio and including Medicare Part C days attributable to dual eligible beneficiaries in the numerator of the Medicaid percentage.

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[7] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[9] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12] The DPP is defined as the sum of two fractions expressed as percentages.[13] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[14]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[15]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under***

[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).
[13] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[14] (Emphasis added.)
[15] 42 C.F.R. § 412.106(b)(2)-(3).

> ***part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[16]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[17]

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

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[18] 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].[19]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[20]

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[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(4).
[18] of Health and Human Services.
[19] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[20] *Id.*

With the creation of Medicare Part C in 1997,[21] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under 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.[22]

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 . . . .*[23]

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."[24] 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*

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[21] 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. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

[22] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

[23] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).

[24] 69 Fed. Reg. at 49099.

> *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.*[25]

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

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.[26] 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).[27] 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, the Secretary 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."[28]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[29]
In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[30] 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.[31] In vacating the final rule, it reasoned that this deprived

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[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.
[28] 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).
[29] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[30] 746 F. 3d 1102 (D.C. Cir. 2014).
[31] *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.").

the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[32] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[33] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[34] A number of hospitals appealed this action. In *Azar v. Allina Health Services* ("*Allina II*"),[35] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[36] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[37] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[38]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[39] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[40]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[41] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

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[32] *Id.* at 2011.
[33] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[34] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).
[35] 139 S. Ct. 1804 (2019).
[36] *Id.* at 1817.
[37] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[38] 139 S. Ct at 1814.
[39] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[40] CMS Ruling 1739-R at 1-2.
[41] 88 Fed. Reg. 37772 (June 9, 2023).

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[42]

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[43]

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because: (1) they failed to appeal from a "final determination" as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1)) and ; and (2) *to the extent the June 2023 Final Rule is* ***in fact*** *applicable to them*, their appeals are premature and their appeal requests failed to meet the content requirements for a request for Board hearing as an individual provider or group appeal as relevant.

A. The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

In filing these group appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed and, to that end, attached a PDF copy of that Final Rule labeled as "Final Determination Document." As this is a final rule (as opposed to an NPR or revised NPR),

[42] *Id.* at 37775 (emphasis added).
[43] 88 Fed. Reg. at 37788 (emphasis in original).

they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) the following in pertinent part:

> **(a) Establishment**
>
> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such section* may obtain a hearing with respect to such payment by the Board, if—
>
> (1) such provider—
>
> (A) . . .
>
> (ii) is dissatisfied with a final determination of the Secretary *as to the amount of the payment* under subsection (b) or (d) of section 1395ww of this title, ...[44]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

Unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[45] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.

[44] (Bold emphasis in original and italics and underline emphasis added.)
[45] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.

> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[46]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost report settlement***."[47] Examples of other adjustments to IPPS payment rates that are based, in

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[46] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

[47] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
>
> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> ****
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

whole or in part, on certain data/costs claimed on the as-filed cost report and then determined and reimbursed through the cost report audit and settlement process include bad debts,[48] direct graduate medical education ("GME"),[49] and indirect GME.[50]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[51]

The four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue but only for certain *open* cost reporting periods relating to discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each***

[48] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).
[49] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").
[50] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).
[51] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

applicable cost reporting period during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[52]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[53]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[54]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[55]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (20 would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of

[52] 88 Fed. Reg. at 37774-75 (emphasis added).
[53] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[54] *Id.* at 37788 (emphasis added).
[55] *Id.* (emphasis added).

an original or revised NPR[56]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[57] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[58]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[59] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.

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[56] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.

[57] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

[58] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[59] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, (as discussed *infra*) the Providers did *not* appeal the publication of SSI fractions but rather the final rule finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy in the June 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

Memorial Hospital concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[60]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[61] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[62] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[63]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[64]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the

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[60] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions.

[61] 2022 WL 888190 at *8.

[62] *Id.* at *9 (emphasis added).

[63] *Id.* at *8.

[64] *Id.* at *9.

hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ."[65] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[66]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was finalized in the June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[67] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[68] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) the hospital's DSH eligibility for relevant period that remains open for resolution (whether for issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[69]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[70] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[71] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[72]

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[65] 795 F.2d at 143 (emphasis added).
[66] *Id.* at 147 (footnote omitted).
[67] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[68] 2022 WL 888190 at *9 (emphasis added).
[69] *See infra* at Section C of the Decision confirming that none of the Providers properly appealed from the alleged publication of SSI fractions "on or about October 15, 2023."
[70] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.
[71] 42 C.F.R. § 405.1840(a), (b).
[72] 42 C.F.R. § 405.1837(c).

B. To the extent the Providers are also attempting to appeal from the alleged publications of SSI Ratios "published on or about October 15, 2023," the Board would similarly dismiss these appeals because the appeal requests are fatally flawed.

To the extent the Providers are also attempting to appeal from the *alleged* publications of SSI Ratios published "*on or about October 15, 2023*", the Board would similarly dismiss these appeals because, notwithstanding the requirements in 42 C.F.R. §§ 405.1837(c) and 405.1835(b), the Providers did not properly identify it as a "final determination being appealed nor did they attach a copy of that publication to their appeal request *as specifically required under those regulations*.[73] A vague reference to CMS posting the alleged publication on its website does not and cannot satisfy the specific regulatory requirement to attach a copy of the final determination being appealed to the appeal request.

To this end, a copy of the actual determination being appealed is needed to confirm a number of basic jurisdictional requirements. In this respect, it is not clear whether each of these Providers were, in fact, included in that alleged publication "on or about October 15, 2023" (much less whether *each Provider's relevant fiscal year* is even open/pending for the DSH SSI Part C issue as discussed in Section C below). Similarly, it is unclear from the appeal requests what years are covered by the *alleged* publication and whether that corresponds to the years under appeal. Finally, the Board notes that the Providers are unsure of the date of the *alleged* publication, and that an *actual* publication date is not documented in the record. As a result, it would be impossible for the Board to determine whether an appeal of the *alleged* publication was timely filed.

Based on the above, it is clear that any Provider claims that they appealed from the *alleged* publication of the SSI rations at issue would be fatally flawed and the Board would exercise its discretion under to dismiss those appeals for failure to comply with the mandatory content requirements for appeal requests located at 42 C.F.R. §§ 405.1837(c) and 405.1835(b).

C. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was, In Fact, Applicable to Them For the Fiscal Years at Issue.

42 C.F.R. § 405.1837(c) specifies the content requirements for a request for a Board hearing as a group appeal.[74] The Providers have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included **any** information related to any relevant NPRs or revised NPRs or any information on any other pending appeal that may have been remanded to the MAC by Court Order and/or CMS Ruling 1739-R*. In this regard, the

[73] 42 C.F.R. § 405.1835(b) states that "the [individual provider appeal] request must include . . . (3) A copy of the final . . . determination under appeal." Similarly, 42 C.F.R. § 1837(c) states that "the request for a Board hearing as a group appeal . . . must include . . . . (3) A copy of each final . . . determination under appeal."

[74] The set of 15 Powers Pyles'-represented appeals referenced in this decision includes individual provider appeals as opposed to CIRP group appeals. The appeals filed on behalf of individual providers failed to meet the requirements set forth at 42 C.F.R. § 405.1835(b), the relevant regulation which outlines a Provider's right to a Board hearing and the content requirements for the appeal.

Board notes that it is the Providers' responsibility under 42 C.F.R. §§ 405.1837(c) and 1835(b) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section." Similar, contents requirements for individual provider appeals are located at 42 C.F.R. § 405.1835(b).

Here, none of the Providers include as part of their appeal requests any documentation relating to which final contractor or Secretary determination they seek to appeal, notwithstanding their responsibilities under 42 C.F.R. §§ 405.1837(c) as quoted above and 405.1835(b) as relevant.

Without having the NPR or any additional documentation on the Providers' final determination as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, *in fact*, applicable to the Provider's for the fiscal years at issue (*i.e*., that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal *through the operation of the June 2023 Final Rule*). Similarly, if the Providers' had remand(s) for the DSH SSI Part C issue for the fiscal years at issue and those remands were still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals; however, the Providers failed to submit any documentation with the appeal requests to confirm any such remands.[75] In this regard, the Board is unable determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' group appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. §§ 405.1837(c) and 405.1835(b), as relevant, requiring its appeal request demonstrate that each of the Providers satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves a payment

[75] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.

D. Multiple Participants Also Can Be Dismissed For Failure to File A Timely Appeal of the June 2023 Final Rule

Powers Pyles directly added the following participants more than 180 days after the publication of the June 2023 Final Rule, as follows, *in 5 different CIRP group cases*:

Provider	Prov. No.	FY	Case No.
Ochsner Med. Ctr. – Westbank LLC	19-0275	2007	24-0425GC
		2008	24-0435GC
Ochsner Baptist Med. Ctr., LLC	19-0135	2010	24-0428GC*
		2011	24-0426GC*
		2013	24-0432GG

* *Note – The dismissal of this participant would result in the group no longer be a valid group appeal as it would fail to meet the minimum number of participants required for a valid group appeal*

Specifically, Powers Pyles directly added each of these participants on December 7, 2023 which is 181 days after the June 2023 Final Rule was published. The Board finds that the direct-add requests (*i.e.*, appeal requests) for the above-5 participants were ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (*i.e.*, appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after* ***notice*** *of the Secretary's final determination.*"[76] The direct-add requests were filed in OH CDMS ***one day past*** the filing deadline of 180 days after the issuance of the June 2023 Final Rule.

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[77] To this end, Board

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[76] (Emphasis added.)

[77] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.

Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[78] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[79] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[80] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[81] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[82] of records of CMS." These laws and regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
>
> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C.

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[78] (Emphasis added.)
[79] *See* 42 C.F.R. § 405.1867.
[80] of the Department of Health and Human Services.
[81] 42 U.S.C. § 1306(a).
[82] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

§ 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[83]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[84]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[85] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[86] Consequently, a provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[87]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[88]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which

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[83] *See also* 42 C.F.R. Part 401, Subpart B.
[84] (Emphasis added).
[85] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[86] *See* http://www.gpo.gov/help/index.html#about_federal_register.htm.
[87] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[88] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).

includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[89]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The above-listed 5 direct-add requests were not filed with the Board until ***one day after this deadline*** (specifically December 7, 2024 and, thus, were not timely filed.[90]

Based on the above findings, the Board concludes that the direct-add requests of Ochsner Med. Ctr. – Westbank LLC (Prov. No. 19-0275) to be added to Case Nos. 24-0425GC and 24-0435GC and the direct-add requests of Ochsner Baptist Med. Ctr., LLC (Prov. No. 19-0135) to be added to Case Nos. 24-0428GC,[91] 24-0426GC,[92] and 24-0432GG failed to meet the claims-filing requirements for a Board hearing request[93] due to the failure of the Providers' to *timely* file their direct-add request to these groups to appeal the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, the Board hereby dismisses them. This is a separate and independent basis to dismiss these 5 participants.

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[89] Emphasis added.

[90] The Providers in these 149 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

[91] Following the dismissal of this participant, the CIRP group under Case No. 24-0428GC would no longer qualify as a valid *fully-formed* group because it would only have one participant and the minimum number for a valid *fully-formed* group is 2 participants.

[92] Following the dismissal of this participant, the CIRP group under Case No. 24-0426GC would no longer qualify as a valid *fully-formed* group because it would only have one participant and the minimum number for a valid *fully-formed* group is 2 participants.

[93] *See* 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

E. Conclusion

The Board finds that: (1) the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); (2) the Providers did not properly appeal the *alleged* publication of the SSI fractions for unspecified years on or about October 15, 2023; and (3) even if the June 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under 42 C.F.R. § 405.1837(c) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule. Further, the Board also as a separate and independent rational dismisses Ochsner Med. Ctr. – Westbank LLC (Prov. No. 19-0275) from Case Nos. 24-0425GC and 24-0435GC and Ochsner Baptist Med. Ctr., LLC (Prov. No. 19-0135) from Case Nos. 24-0428GC, 24-0426GC, and 24-0432GG because they failed to meet the claims-filing requirements for a Board hearing request due to their failure to *timely* file their direct-add request to join the relevant group. Based on the foregoing, the Board hereby dismisses the 15 group appeals listed in **Appendix A** in their entirety and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/12/2024

X Clayton J. Nix

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

Enclosure: **Appendix A** – Listing of 12 CIRP Groups and 3 Individual Appeals

cc: Michael Redmond, Novitas Solutions, Inc. (J-H), (J-L)
Jacqueline Vaugh, OAA
Wilson Leong, FSS

APPENDIX A
Listing of 15 CIRP and Optional Groups

CASE NO.	CASE NAME
24-0405	Ochsner Medical Center (19-0036), FFY 2023 (10/1/2004 – 12/31/2004)
24-0406	Ochsner Medical Center (19-0036), FFY 2023 (1/1/2005 – 12/31/2005)
24-0407	Ochsner Medical Center (19-0036), FFY 2023 (1/1/2006 – 12/31/2006)
24-0413GC	Ochsner Health Sys. CY 2009 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0414GC	Ochsner Health Sys. CY 2012 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0415GC	Ochsner Health Sys. CY 2014 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0417GC	MedStar Health CY 2010 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0419GC	MedStar Health CY 2009 Treatment of Medicare Part C Days in the DSH Calc. CIRP Group
24-0422GC	MedStar Health CY 2008 Treatment of Medicare Part C Days in the DSH Calc. CIRP Group
24-0423GC	MedStar Health CY 2007 Treatment of Medicare Part C Days in the DSH Calc. CIRP Group
24-0425GC	Ochsner Health Sys. CY 2007 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0426GC	Ochsner Health Sys. CY 2011 Treatment of Medicare Part C Days for the DSH Calc. CIRP Grp
24-0428GC	Ochsner Health Sys. CY 2010 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0432GC	Ochsner Health Sys. CY 2013 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp
24-0435GC	Ochsner Health Sys. CY 2008 Treatment of Medicare Part C Days in the DSH Calc. CIRP Grp

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Jeffrey Haeffner
Northwell Health
972 Brush Hollow Road
Westbury, NY 11590

RE: ***Dismissal for Untimely Filing Pursuant to Board Rules 20 and 20.1***

Northwell Health CY 2014 SSI Baystate Errors CIRP Group
Case Number: 19-0186GC

Dear Mr. Haeffner:

The Provider Reimbursement Review Board (the "Board") has reviewed the subject common issue related party ("CIRP") group appeal in response to a February 15, 2024 "Rule 22 Jurisdictional Review" letter filed by the Medicare Contractor and the Board's subsequent February 16, 2024 "Scheduling Order Rule 20/20.1 Certification." A brief history of the facts and the Board's determination are set forth below.

Pertinent Facts:

On **October 18, 2023**, Northwell Health ("Group Representative") designated the CIRP group to be fully formed. On the same date, the Board issued a Critical Due Dates ("CDD") which set the Parties' preliminary position paper due dates and reminded that "[t]he parties are responsible for pursuing the appeal in accordance with the Board's Rules." In accordance with those rules, a PDF copy of the Schedule of Providers ("SoP") with Support or a Rule 20 Certification should have been filed within 60 days of the group's full formation.

On **December 13, 2023**, Northwell Health filed a preliminary position paper which included exhibits listing nine group participants and separate exhibits with the respective jurisdictional support for those participants. The Board notes that the list of participants was not filed in the proper format (i.e., Model Form G), nor was the jurisdictional support submitted pursuant to the direction provided in the Board Rules.

On **February 15, 2024**, the Medicare Contractor filed its "Rule 22 Jurisdictional Review" and advised that the Group failed to file its Rule 20 certification or a SoP with support by the deadline. The Medicare Contractor indicated that it had reviewed the documentation & support in OH CDMS and found significant errors in the record.

On **February 16, 2024**, the Board issued a Scheduling Order in which it directed the Group to

file its Rule 20 Certification or a PDF copy of the SoP **with support** in accordance with Board Rule 20.1. Northwell Health was directed to use "other case correspondence" to upload its response by March 1, 2024. The Board also noted that, although jurisdictional documentation may have been previously submitted as exhibits to its preliminary position paper, Rule 20 Certifications and/or Rule 20.1 submissions must be stand-alone filings and never part of another filing (e.g., never embedded within a preliminary position paper filing, group status response, etc.).

To date there has been no response to the Board's Scheduling Order. As set forth below, Northwell Health has failed to meet the requirements of Rules 20 and 20.1. Below is a discussion regarding Rule 20 and Rule 20.1 requirements and the information that was required in this case.

Rule 20/20.1 Background:

Rule 20 addresses the population of Issues/Providers in OH CDMS. Pursuant to Board Rule 20:

> If ***all*** the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the representative is exempt from filing a ***hard copy*** of the schedule of providers with supporting jurisdictional documentation. In this instance, the Board uses the schedule of providers and supporting jurisdictional documentation that is created in OH CDMS using the information and documents included in each participating provider's request for transfer or direct add to the group.
>
> ***Prior to*** certifying that the group is fully formed or the date on which a group is fully formed, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[1] If *all* of the participants in a fully-formed group are ***populated*** under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, the group representative must file a statement certifying that the group is *fully* populated in OH CDMS with the relevant supporting jurisdictional documentation (*i.e.*, all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[2]

[1] If all participants are populated but jurisdictional support is not complete, the Rule 20 Certification must certify that all participants are populated but should include an identification of the documents that are missing and then ***only*** file in OH CDMS those additional missing documents. See, https://www.cms.gov/files/document/oh-cdms-prrb-user-manual-supplement-supplemental-document-uploads-individual-appeals.pdf.
[2] (Underline emphasis added.)

Board Rule 20.1 applies to **"Group Cases that Are Not Fully Populated in OH CDMS."** Pursuant to Board Rule 20.1:

> If any participants in a fully-formed group are ***not*** populated under the Issues/Providers Tab in OH CDMS with supporting jurisdictional documentation (*see* Rule 21), then the Representative must prepare a traditional schedule of providers (*i.e.* Model Form G at Appendix G), for <u>*all*</u> participants in the group **following the instructions in this Rule and Rule 21, unless the Board instructs otherwise.** Specifically, *within sixty (60) days of the full formation of the group* (see Rule 19), the group representative must prepare and file a schedule of providers with the supporting jurisdictional documentation for all providers in the group that demonstrates that the Board has jurisdiction over each participant named in the group appeal (*see* Rule 21) . . . .

Upon review, the Board notes that there are nine providers included in the listing Northwell Health submitted with its preliminary position paper on December 13, 2023, and all nine providers appear to be populated behind the Participants tab in Case No. 19-0186GC. Therefore, it appears that Rule 20 would apply in this group. Consequently, the Representative should have filed a Rule 20 Certification by the March 1, 2024 deadline set forth in the Board's February 16, 2024 Scheduling Order.[3]

<u>Board Determination</u>:

Pursuant to 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***;**

[3] Rule 20/20.1 Certifications must be stand-alone filings and never part of another filing *(e.g., never embedded within a preliminary position paper filing, group status response, etc.).*

(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.

Because the Rule 20 Certification was not timely filed, the Board hereby dismisses the subject group appeal pursuant to its authority under 42 C.F.R. § 405.1868. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

3/14/2024

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Board Decision* – SSI Percentage (Provider Specific) & Medicaid Eligible Days Issues**
Affinity Medical Center (Provider Number 36-0151)
FYE: 02/11/2018
Case Number: 21-1764

Dear Mr. Ravindran and Ms. Cummings,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. *Procedural History for Case No. 21-1764*

On March 3, 2021, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end February 11, 2018.

On August 24, 2021, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

As the Provider is owned by Quorum Health Corporation (hereinafter "Quorum Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issue 2 to Quorum Health groups on March 29, 2022. As a result, the remaining issues in this appeal are Issues 1 and 3.

On April 3, 2022, the Provider filed its preliminary position paper.

[1] On March 29, 2022, this issue was transferred to PRRB Case No. 22-0977GC.

On June 30, 2022, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 3.

On August 4, 2022, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 22-0977GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[2]

As the Provider is commonly owned by Quorum Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 22-0977GC, Quorum Health CY 2018 DSH SSI Percentage CIRP Group, on March 29, 2022. The Group Issue Statement in Case No. 22-0977GC reads, in part:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's [DSH]/[SSI] percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in

[2] Issue Statement at 1 (Aug. 24, 2021).

> accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) 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,
> 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]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $14,000.

On April 3, 2022, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (February 11).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR

[3] Group Issue Statement, Case No. 22-0977GC.

> data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4]

MAC's Contentions

Issue 1 – DSH Payment/ SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the appeal is premature:

> Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. § 405.1835, the Board has jurisdictional authority only to hear appeals concerning costs claimed on a timely filed cost report if the provider is dissatisfied with the final determination of the Medicare Contractor. For SSI% realignment, there is no final determination from which the Provider can demonstrate its dissatisfaction. A Provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact. The Provider's appeal of this item is premature. To date the Provider has not formally 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. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[5]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[6]

Finally, the MAC argues "the Provider did not file a **complete** preliminary position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[7] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[8] In more detail:

[4] Provider's Preliminary Position Paper at 8-9 (Apr. 3, 2022).
[5] Jurisdictional Challenge at 6 (June 30, 2022).
[6] *Id*. at 4-5.
[7] *Id*. at 6.
[8] *Id*. at 8.

> Within its Provider's Preliminary Position Paper, the Provider makes the broad allegation that "The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation" yet offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Providers failed to include any evidence to establish the material facts in this case relating to inaccuracies in the SSI Percentage calculation at issue or any evidence pertaining to the alleged systemic SSI ratio data match errors like those referenced in the *Baystate* case. The Provider merely repeats their appeal request which itself is a verbatim recitation of the deficiencies that the Board found in the *Baystate* case.[9]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC requests that the Board find the Provider abandoned the DSH – Medicaid Eligible Days issue, arguing:

> The MAC contends that the Provider was in violation of Board Rule 25.3 when it failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its preliminary position paper. Moreover, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2. Accordingly, the DSH – Medicaid Eligible Days issue should be dismissed.
>
> Within its Provider's preliminary position paper, the Provider makes the broad allegation, ". . . the Provider contends that the total number of days reflected in its' [sic] 2017 cost report does not reflect an accurate number of Medicaid eligible days. . ." The Provider has failed to include any evidence to establish the material facts in this case relating to inaccuracies in the Medicaid Percentage calculation at issue. The Provider merely repeats its appeal request.[10]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[11] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board

[9] *Id*.
[10] *Id*. at 10.
[11] Board Rule 44.4.3, v. 3.1 (Nov. 2021).

Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2020), 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.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 22-0977GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[13] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'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."[14]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 22-0977GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds the

[12] Issue Statement at 1.
[13] *Id.*
[14] *Id.*

DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 22-0977GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6,[15] the Board dismisses this aspect of the DSH Payment/SSI Percentage (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 pursuing that issue as part of the group under Case No. 22-0977GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[16] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 22-0977GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 22-0977GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* then provide the following information in the position papers:
>
> 1. Identify the missing documents;

[15] PRRB Rules v. 3.1 (Nov. 2021).
[16] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

2. Explain why the documents remain unavailable;
3. State the efforts made to obtain the documents; and
4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.[17]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [18]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[19]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra,* No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

[17] (Emphasis added).
[18] Last accessed March 8, 2024.
[19] Emphasis added.

Accordingly, the Board finds that Issue 1 in the instant appeal and the group issue from Group Case 22-0977GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. DSH Payment – Medicaid Eligible Days

According to its Appeal Request, the Provider asserts that all Medicaid Eligible Days were not included in the calculations of the DSH calculation. The Provider states Issue 3 as:

> **Statement of the Issue**
>
> Whether the MAC properly excluded Medicaid eligible days from the Disproportionate Share Hospital ("DSH") calculation.
>
> **Statement of the Legal Basis**
>
> The Provider contends that the MAC did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i). Specifically, the Provider disagrees with the calculation of the second computation of the disproportionate patient percentage, set forth at 42 CFR § 412.106(b) of the Secretary's Regulations.
>
> The MAC, contrary to the regulation, failed to include all Medicaid eligible days, including but not limited to Medicaid paid days, unpaid eligible days, eligible days adjudicated and processed after

[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Quorum Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

> the cutoff date and all out of State eligible days in the Medicaid Percentage of the Medicare DSH calculation.[21]

The Provider failed to include a listing of the additional Medicaid eligible days they expect to be included in their Medicaid percentage and DSH computations with their appeal request.

The Provider's preliminary position paper indicated that it would be sending the eligibility listing under separate cover.[22]

Board Rule 7.3.1.2 states:

> **No Access to Data**
>
> If the provider elects not to claim an item on the cost report because, through no fault of its own, it did not have access to the underlying information to determine whether it was entitled to payment, describe the circumstances why the underlying information was unavailable upon the filing of the cost report.

In the instant case, the Provider neglected to include all supporting documentation, or alternatively, state the efforts made to obtain documents which are missing and/or remain unavailable, in accordance with Board Rule 25.2.2.

Notably, the Provider has not included a list of additional Medicaid eligible days with its preliminary position paper or submitted such list under separate cover. The Provider has essentially abandoned the issue by failing to properly develop its arguments and to provide supporting documents or to explain why it cannot produce those documents, as required by the regulations and the Board Rules.[23]

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (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*.

[21] Individual Appeal Request, Issue 3.
[22] Provider's Preliminary Position Paper at 8.
[23] *See also* Board's jurisdictional decision in *Lakeland Regional Health* (Case No. 13-2953, 11/20/2019), in which the Board found a Provider essentially abandoned its appeal by filing a position paper that failed to set forth the merits of its claim, explain why the agency's calculation was wrong, and identifying missing documents to support its claim and to explain why those documents remained unavailable.

> (3) In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper. *Exhibits regarding the merits of the provider's Medicare payment claims may be submitted in a timeframe to be decided by the Board through a schedule applicable to a specific case or through general instructions*.[24]

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

> If the provider, through no fault of its own, does not have access to the underlying information to determine whether the adjustment is correct, describe why the underlying information is unavailable.

Similarly, with regard to position papers,[25] Board Rule 25.2.1 requires that "the parties must exchange ***all*** *available* documentation as exhibits to fully support your position."[26] This requirement is consistent with 42 C.F.R. § 405.1853(b)(3).

Similarly, consistent with that regulation, Board Rule 25.2.2 provides the following instruction on the content of position papers as it relates to unavailable documentation/exhibits:

> *If documents necessary to support your position are still unavailable*, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party.[27]

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(4)(iii) places the burden of production on the provider, stating:

> The hospital has the burden of furnishing data adequate to prove eligibility for each Medicaid patient day claimed under this

[24] (Emphasis added).
[25] The minimum requirements for Final Position Paper narratives and exhibits are the same as those for Preliminary Position Papers. *See* Board Rule 27.2.
[26] (Emphasis added).
[27] (Emphasis added).

> paragraph, and of verifying with the State that a patient was eligible for Medicaid during each claimed patient hospital day.

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

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

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

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

The Board concurs with the Medicare Contractor that the Provider is required to identify and provide documentation to prove what additional Medicaid Eligible days are at issue and to which it may be entitled, consistent with 42 C.F.R. § 405.1853(b)(2)-(3) and Board Rule 25. Further, pursuant to 42 C.F.R. § 412.106(b)(iii), the Provider has the burden of proof "to prove eligibility for ***each*** Medicaid patient day claimed"[28] and, pursuant to Board Rule 25, the Provider has the burden to present that evidence as part of its position paper filing unless it adequately explains therein why such evidence is unavailable. Based on the record before the Board, the Board finds that the Provider has failed to provide a listing or other supporting documentation for the Medicaid Eligible Days issue as required by the controlling regulations and Board Rules. Nor has the Provider provided any explanation as to why the documentation was absent or what is being done to obtain it, consistent with Board Rule 25.2.2. Indeed, without any days identified in the position paper filing, the Board must assume that there are no days or amount in dispute for this issue.

The Board finds that the Provider has failed to comply with the Board's procedures with regard to filing its position papers and supporting documentation. Specifically, the Board finds that the Provider has failed to satisfy the requirements of Board Rules 25.2.1 and 25.2.2 related to identifying the days in dispute and the submission of documentary evidence required to support its claims or describe why said evidence is unavailable, which the Provider has failed to do.[29]

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[28] (Emphasis added).
[29] Board Rule 25, of which 25.2 (A) and 25.2 (B) are a part, is applicable to final position papers via Board Rule 27.2.

Accordingly, the DSH Payment – Medicaid Eligible Days issue is dismissed.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 22-0977GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. The Board also dismisses the DSH Payment - Medicaid Eligible Days issue as the Provider failed to meet the Board requirements for position papers for this issue in compliance with 42 C.F.R. §§ 412.106(b)(4)(iii) and 405.1853(b)(2)-(3) and Board Rule 25. As no issues remain pending, the Board hereby closes Case No. 21-1764 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/19/2024

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Community Health Systems, Inc.
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Michael Redmond
Novitas Solutions, Inc.
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RE: ***Board Decision***
Regional Hospital of Scranton (Prov. No. 39-0237)
FYE 06/30/2016
Case No. 19-0668

Dear Messrs. Summar and Redmond:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the documentation in Case the above captioned appeal. The Board's decision is set forth below.

Background:

A. Procedural History for Case No. 19-0668

On June 6, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2016. On December 5, 2018, the Board received the Provider's individual appeal request. The appeal request contained the following five issues:

1. DSH/SSI Percentage (Provider Specific),
2. DSH/SSI Percentage (Systemic Errors),[1]
3. DSH Payment Medicaid Eligible Days,
4. UCC Distribution Pool, and
5. 2 Midnight Census IPPS Payment Reduction.[2]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2 and 5 to Community Health groups on July 18, 2019. On March 1, 2024, the Provider withdrew Issue 3 from the appeal. As a result, the remaining issues in this appeal are Issues 1 and 4.

[1] On July 18, 2019, this issue was transferred PRRB Case No. 19-1409GC (CHS CY 2016 DSH SSI Percentage CIRP Group).
[2] On July 18, 2019, this issue was transferred to PRRB Case No. 19-1410GC (CHS CY 2016 Two Midnight Census IPPS Payment Reduction CIRP Group).

On May 9, 2019, the Medicare Contractor filed a jurisdictional challenge in the appeal. The Medicare Contractor challenges jurisdiction over Issues 1, 4 and 5.

On August 5, 2019, the Provider submitted its preliminary position paper. On November 26, 2019, the Medicare Contractor filed its preliminary position paper.

On January 3, 2024, the Provider filed its Final Position Paper. On January 30, 2024, the Medicare Contractor filed its Final Position Paper.

A. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 19-1409GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation. . . .
>
> 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. [Section] 1395(d)(5)(F)(i).[3]

In PRRB Case No. 19-1409GC, Community Health Systems CY 2016 DSH SSI Percentage CIRP Group, which is being appealed from the same NPR as the instant appeal for the same fiscal year end, the Providers described their DSH/SSI Percentage (Systemic Errors) issue as whether the Medicare/SSI fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. The Group Issue Statement in Case No. 19-1409GC reads:

> **Statement of the Issue:**
>
> Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

[3] Appeal Request, Tab 3 Appeal Issues at 1 (Dec. 5, 2018).

Statement of the Legal Basis

The Provider(s) contend(s) 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(s) further contend(s) 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,
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.

COVERED DAYS VS. TOTAL DAYS

The statutory language defines the Medicare/SSI fraction as consisting solely of days for patients who were "entitled to benefits under part A" of Medicare. The numerator includes only those Part A days for patients who are also entitled to SSI benefits. The denominator of the Medicare/SSI fraction includes all Part A days. As set forth in the statutory language above, the numerator of the Medicaid fraction consists of days of patients who were both eligible for medical assistance under Title XIX, or Medicaid, and not entitled to benefits under Part A of Title XVII, or Medicare. The denominator for the Medicaid fraction is the hospital's total patient days for the period.

CMS considers an individual to be "entitled to benefits under Part A" regardless of whether the days were "covered" or paid by Medicare. This means that now Part C days, Exhausted Benefit days, and Medicare Secondary Payer ("MSP") days are included in the denominator of the Medicare/SSI fraction even when there is no payment by Medicare, which is a departure from the treatment of these days as excluded from the Medicare/SSI fraction prior to the 2004 rule.

The Provider(s) contend(s) that if CMS includes unpaid Medicare Part A days in the denominator of the Medicare/SSI fraction, then unpaid SSI

> eligible patient days must be included in the numerator of the Medicare/SSI fraction, utilizing SSI payment codes that reflect the individuals' eligibility for SSI – even if the individuals did not receive SSI payments, as a matter of statutory consistency.

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $18,000.

On July 31, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**
>
> The Provider contends that its' SSI percentage published by the Centers for Medicare and Medicaid Services ("CMS") was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (June 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 97-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[4]

On January 4, 2024, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Calculation of the SSI Percentage**

[4] Provider's Preliminary Position Paper (July 31, 2019) at 8-9.

> The Provider contends that the MAC's determination of Medicare Reimbursement for DSH Payments are not in accordance with the Medicare statute 42 U.S.C. 1395ww(d)(5)(F)(i). The Provider contends that the SSI percentage calculated by [CMS] and used by the MAC to settle their Cost Report was incorrectly computed because of the following reasons:
>
> **Issue #1 Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al. v. Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[5]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC contends that the component of Issue 1 which addresses SSI data accuracy is duplicative of Issue 2. The MAC also argues that the component of Issue 1 addressing individuals who are eligible for SSI but did not receive SSI payments is duplicative of Issue 2. The Medicare Contractor asks the Board to dismiss these components of Issue 1 as duplicative of Issue 2 which resides in PRRB Case No. 19-1409GC.[6]

The MAC argues that the Board lacks jurisdiction over the component of Issue 1 requesting realignment because:

[5] Provider's Final Position Paper (Jan. 4, 2024) at 8-9.
[6] Jurisdictional Challenge at 3-4 (May 9, 2019).

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final MAC determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact. . . .
>
> The Provider's appeal is premature. To date 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. The MAC requests that the PRRB dismiss this issue consistent with recent jurisdictional decisions.[7]

Issue 4 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[8] Additionally, the MAC asserts that the Provider was a participant in PRRB Group Case No. 15-1134GC which was for the same issue as Issue 4 in this appeal. The MAC states that the PRRB dismissed Group Case No. 15-1134GC on July 30, 2018, and that pursuant to PRRB Rule 12.3.1 that "appeals of the same issue from distinct determinations must be pursued in a single appeal." The MAC requests the Board to dismiss Issue 4 from this appeal.[9]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[10] The Provider has not filed a response to the Jurisdictional Challenge or Motion to Dismiss and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record." Similarly, Board Rule 44.3 specifies with respect to motions that "[u]nless the Board imposes a different deadline, an opposing party may send a response, with relevant supporting documentation, within 30 days from the date that the motion was sent to the Board and opposing party."

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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

[7] *Id.* at 4.
[8] *Id.* at 5-6.
[9] *Id.* at 6.
[10] Board Rule 44.4.3, v. 2.0 (Aug. 2018).

$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.

A. DSH Payment/SSI Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue. The jurisdictional analysis for Issue No. 1 has several relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage; 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period; and 3) the Provider incorporating the arguments from *Advocate Christ*[11] into its appeal.

1. First and Third Aspects of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage issue that was appealed in PRRB Case No. 19-1409GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[12] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[13] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'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."[14]

The Provider's DSH/SSI Percentage issue in group Case No. 19-1409GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage issue in Case No. 19-1409GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[15], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

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[11] The Provider has included the Appellants' Reply Brief in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214 (D.C. Cir.), which is on appeal from the decision in *Advocate Christ Med. Ctr. V. Azar*, 17-cv-1519 (TSC), 2022 WL 2064830, (D.D.C. June 8, 2022).
[12] Appeal Request, Tab 3 Appeal Issues at 1.
[13] *Id.*
[14] *Id.*
[15] PRRB Rules v. 2.0 (Aug. 2018).

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 19-1409GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[16] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 19-1409GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 19-1409GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[17]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the*

[16] 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).
[17] (Emphasis added).

Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[18] This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[19]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 19-1409GC are the same issue.[20] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, regarding the third aspect of Issue 1, the Provider states in its Final Position Paper that "[t]he [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v. Xavier Becerra (Appellants reply brief included as Exhibit P-3)." The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (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.*[21]

[18] Last accessed February 24, 2023.
[19] Emphasis added.
[20] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[21] (Emphasis added).

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument, and dismisses that portion of the issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[22]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

[22] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[23] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[24] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[25] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[26]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[27]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[28] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[29] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the

[23] 830 F.3d 515 (D.C. Cir. 2016).
[24] 89 F. Supp. 3d 121 (D.D.C. 2015).
[25] 830 F.3d 515, 517.
[26] *Id.* at 519.
[27] *Id.* at 521-22.
[28] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[29] *Id.* at 506.

choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[30]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[31] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[32] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[33] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[34] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[35]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[36]

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

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

wrong period."[37] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[38] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[39]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[40] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[41] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[42] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[43] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[44] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[45]
The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2015 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and

[37] *Id.* at 265.
[38] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[39] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[40] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[41] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[42] *Id.* at *4.
[43] *Id.* at *9.
[44] 139 S. Ct. 1804 (2019).
[45] *Ascension* at *8 (bold italics emphasis added).

underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

In summary, the Board dismisses the DSH SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 19-1409GC and there is no final determination from which the Provider can appeal the SSI realignment aspect of this issue. Additionally, the Boad dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review.

As there are no remaining issues in this appeal, Case No. 19-0668 is now closed. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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For the Board:

3/25/2024

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Signed by: PIV

cc:Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***Closure of Group Appeals Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii)***
Case No. 14-2873GC – Ardent Health Servs 2010 Post 1498-R DSH Medicaid Fraction Dual Elig. Days[1]
Case No. 14-2874GC – Ardent Health Servs. 2010 Post 1498-R DSH SSI Fraction Dual Eligi. Days CIRP
Case No. 14-3717GC – Ardent Health Servs. 2011 Post 1498-R DSH Medicaid Fraction Dual Elig. Days[2]
Case No. 14-3718GC – Ardent Health Servs. 2011 Post 1498-R DSH SSI Fraction Dual Elig. Days CIRP

Dear Messrs. Ravindran and Berends:

As the parties are aware, James Ravindran of Quality Reimbursement Services, Inc. ("QRS" or "Group Representative"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") on June 4, 2022 involving, in the aggregate, four (4) group cases and twenty-two (22) participants. As discussed in further detail *infra*, *unbeknownst to the Board*, QRS filed a complaint on behalf of the Providers in these 4 group cases in the U.S. District Court for the District of Columbia ("D.C. District Court") on June 7, 2022,[3] ***only three (3) days after the EJR request had been filed with the Board***, in order to bypass the Board proceedings and pursue the merits of these 4 group cases in federal court. On July 22, 2022, the Board issued a determination denying the *consolidated* EJR request, dismissing the no-pay Part A days issue in Case Nos. 14-2874GC and 14-3718GC, and dismissing two of these group cases, Case Nos. 14-2873GC and 14-3717GC; however, the Board did so without knowledge of that lawsuit having been filed. As set forth below, the Board rescinds its July 22, 2022 determination as void in the first instance and closes these 4 group cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii).[4]

On **June 29, 2022**, the Board issued a Scheduling Order ("Scheduling Order") for all 4 group cases in the *consolidated* EJR request. The Scheduling Order noted that the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*")[5] 20 days ***after*** QRS filed the instant EJR request. Since the *Empire* decision was directly relevant to the issues in the EJR

[1] Dismissed by the Board on August 3, 2023 but without knowledge of the lawsuit previously filed by QRS almost 2 months earlier on June 7, 2022. *See infra* note 3 and accompanying text.
[2] Dismissed by the Board on August 3, 2023 but without knowledge of the lawsuit previously filed by QRS almost 2 months earlier on June 7, 2022. *See infra* note 3 and accompanying text.
[3] *Lovelace Med. Ctr. Downtown. v. Becerra*, Case No. 1:22-cv-01623 (D.D.C., filed June 7, 2022). A copy of this complaint is attached to the QRS letter filed with the Board on August 31, 2022.
[4] In review of its docket, the Board has identified these cases that are similar to other QRS cases involving the same type of closure circumstances triggered by 42 C.F.R. § 405.1842(h)(3)(iii) as needing to be closed but, unfortunately, were not closed earlier. *See also infra* notes 41-43 and accompanying text discussing the 642 group cases involving 2000+ participants that were filed during this time period and the complex procedural history surrounding that concentrated volume of EJR requests.
[5] 142 S.Ct. 2354 (2022).

Request, but the request and responses did not discuss the case, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to issue a Scheduling Order requiring QRS to file a response within 21 days (*i.e.*, by Wednesday July 20, 2022):

1. Giving updates on whether the participants of *each* group were still pursuing the merits of the *consolidated* EJR Request;
2. Requesting withdrawals for each case not being pursued; and
3. Updating or clarifying, as relevant, the EJR request to discuss the impact of *Empire* on the *consolidated* EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction for each case being pursued.[6]

The Scheduling Order also notified the parties that "the 30-day period for responding to the EJR requests has not yet commenced for these [4] CIRP group appeals and will not commence until the Board completes its jurisdictional review of the these CIRP groups."[7] As part of its detailed explanation, the Board noted that "in implementing 42 U.S.C. § 1395oo(f)(1), the Secretary has made clear at 42 C.F.R. § 405.1842 that the 30-day period 'does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete.'"[8] *Following the Board's Scheduling Order, QRS filed* ***no objections*** *or requests for clarification with regard to the Scheduling Order itself.* As a result, the Board and FSS continued to take actions consistent with that Scheduling Order. The Medicare Contractors were required to file, through FSS, any response to QRS' response no later than 21 days after it was filed.

On **July 20, 2022**, QRS *timely* filed the Providers' response to the Scheduling Order. It noted that the Providers in all 4 CIRP group cases remained committed to pursuing the consolidated EJR request and that none would be withdrawn. It recognized that "the Empire decision [held] that exhausted days are properly includable in the Medicare fraction and . . . that 'entitled' and 'eligible' have the same meaning for purposes of the Medicare fraction."[9] In light of the *Empire* decision, QRS then stated that it "intend[ed] to submit an ***updated*** EJR Requests to focus on the numerator of the Medicare Fraction, insofar as only 'paid' days are included there, and not also 'eligible' (a/k/a 'entitled' days)."[10] As a result, QRS "request[ed] an additional 14 days in which to submit their updated EJR requests."[11] Again, QRS' response did *not* include any objection to the Board's notice that the 30-day period to review an EJR request had not begun, *nor* did it notify the Board of the lawsuit it had already filed roughly 1½ months earlier on June 7, 2022.

On **July 22, 2022**, the Board issued a Denial of EJR Requests and Scheduling Order. It noted that QRS' July 20, 2022 response was, at best, incomplete and sought additional time to brief *Empire*

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[6] The Board noted this information was necessary for the Board to determine jurisdiction over the groups and underlying participants and, if the Board found the prerequisite jurisdiction (see 42 C.F.R. § 405.1842(b)(1)-(2)), to then rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii).
[7] Board letter dated June 29, 2022 for Case Nos. 14-2873GC, *et al*. at 1.
[8] *Id.* at 3 (quoting 42 C.F.R. 405.1842(b)(2) (emphasis added)).
[9] QRS letter dated July 20, 2022 at 2.
[10] *Id*. (emphasis added).
[11] *Id.*

along with a new issue focusing on "paid days" included in the numerator of the Medicare Fraction. The Board found that QRS failed to brief the *Empire* decision as required by the Board's Scheduling Order and denied the request for additional time to do so, noting that QRS waited until the ***final*** day to request an extension to file its response to the Board's RFI. Accordingly, the Board:

1. Denied the originally-filed *consolidated* EJR Requests for all four (4) cases because: (a) a group may contain only one issue pursuant to 42 C.F.R. § 405.1837(a); (b) "it is clear from the response that, due to the Supreme Court's decision in *Empire*, the Providers are ***not*** pursuing the invalidation of the Secretary policy to count no-pay Part A days in the Medicare fraction as adopted in the FY 2005 IPPS Final Rule (the "No-Pay Part A Policy") and, through that invalidation seeking to have no pay Part A days excluded from the Medicare fraction and, to the extent those days involve dually eligible patients, included in the numerator of the Medicaid fraction"; and (c) instead, "QRS has represented that there is a ***new*** *and separate issue* in these CIRP groups involving only the numerator of the Medicare fraction."[12]

2. Dismissed the No-Pay Part A Days issue from Case Nos. 14-2874GC and 14-3718GC "since it is clear that [as a result of *Empire*,] QRS is not pursuing the No-Pay Part A Policy (and failed to otherwise timely brief that issue per the Board's [June 29, 2022] RFI."

3. Dismissed Case Nos. 14-2873GC and 14-3717GC since these cases only relate to the *Medicaid* fraction and could not relate to the alleged new issue since the new issue clearly only pertains to the numerator of the DSH Medicare fraction.

For the remaining two (2) cases, Case Nos. 14-2874GC and 14-3718GC, the Board noted that QRS needed to request bifurcation in order to pursue any new issues no later than September 1, 2022. It noted that any bifurcation requests would need to include: (i) the original group issue statement with an explanation of how the new issue was included therein; (ii) an explanation of how any new issues had not been abandoned in filings made in each CIRP group case; (iii) an explanation of how each amount in controversy calculation contemplated the issue decided in *Empire* and any newly sought issues; and (iv) for participants who were transferred from individual appeals, an explanation of how it included any newly sought issues in its original appeal request.

On **August 2, 2022**, QRS filed a letter ***incorrectly*** asserting that the Board had not ruled on or replied to QRS' July 20, 2022 response to the Board's June 29, 2022 Scheduling Order. QRS failed to recognize the Board's prompt July 22, 2022 ruling in these 4 CIRP groups.

On **August 31, 2022**, QRS timely filed its response to the Board's July 22, 2022 Scheduling Order. Within its response, QRS obliquely notified the Board that it had commenced an action in federal court and served the Secretary of Health and Human Services on August 18, 2022 and attached a copy of the Complaint filed to initiate that lawsuit on June 7, 2022. At this late date, QRS then insisted that "the Board does not possess jurisdiction over these cases *because they have been* ***filed***

[12] (Emphasis added.)

in federal court [since June 7, 2022]"[13] and the Board now lacked jurisdiction to dismiss or take any action in these cases as a result of the federal court filing. Nevertheless, without legal analysis[14] or reference to the original group appeal request (or other jurisdictional documents) underlying each of these group appeal, QRS ***summarily*** argued that the appeals at issue here all included challenges to an alternate issue (whether all patients entitled to SSI, whether or not a payment was received during hospitalization, should be included in the numerator of the DSH Medicare Fraction).

A review of public records confirmed that QRS had filed the lawsuit in federal court eighty-five (85) days prior to its August 31, 2022 notice to the Board and, more egregiously, just ***3 days after the EJR request was filed with the Board***. Specifically, on June 7, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a complaint in the D.C. District Court, under Case No. 1:22-cv-01582, seeking judicial review on the merits of its EJR Request in these 4 CIRP group cases. This is less than the prescribed 30-day period for the Board to review an EJR request and demonstrates that QRS had *no intention* of allowing the Board to process its *consolidated* EJR requests pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation at 42 C.F.R. § 405.1842 that implemented the statutory provision. QRS' failure to *immediately* notify the Board and the opposing parties of this June 7, 2022 filing of the lawsuit demonstrates QRS' lack of good faith and the disingenuous nature of its filings before the Board.

QRS' egregious action in these cases is not new to the Board. To provide context for these cases, and the ongoing malfeasance by QRS, the Board attaches and incorporates a copy of the Board's June 10, 2022 closure letter, in response to QRS initiating federal litigation in connection with the consolidated EJR request QRS filed on January 20, 2022 involving 80 group cases for the same issue with 950+ participants in the aggregate, as **Appendix B**.

Procedural Background:

The Scheduling Orders issued in these cases explained that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "the 30-day period for [the Board] responding to the EJR request has not yet commenced for these CIRP group appeals and will not commence until the Board completes its jurisdictional review of these CIRP groups." The Board also explained that a Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842.

The Board's conclusion that the 30-day period had not begun is further supported by 42 C.F.R. § 405.1842(b)(2) which states in pertinent part: "the 30-day period for the Board to make a determination under [42 U.S.C. § 1395oo(f)(1)] does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." Accordingly, 42 C.F.R. § 405.1842(a)(4)(ii)

[13] QRS letter dated Aug. 31, 2022 at 2.

[14] Legal analysis would include reference to each provider's right to appeal whether under 42 C.F.R. §§ 405.1835(a), (c) or 405.1837(a) and the content requirements for those appeal requests under 42 C.F.R. §§ 405.1835(b), (d) or 405.1837(c) as relevant. For example, the Board notes that § 405.1835(c) states that a group appeal request "***must*** *include* all of the following . . . . (3) . . . *a* ***precise*** *description of the* ***one question*** of . . . ***interpretation of law***, regulations, or CMS Rulings that is common to the particular matter at issue in the group appeal." (Emphasis added.)

states that a provider may seek EJR review in federal court without an EJR determination by the Board, "*only if* . . . [t]he Board fails to make a determination of its authority to decide the legal question no later than 30 days *after* finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete." Consistent with these regulatory provisions, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established **prior to** granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** *it determines whether it has jurisdiction and the request for EJR is complete*. *See* 42 C.F.R. § 405.1842.[15]

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

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to the Scheduling Orders issued in these cases, and in fact requested *additional* time to comply and participate with the Board's June 29, 2022 Scheduling Order.

QRS made clear by filing the Complaint (*i.e.*, "the lawsuit"[16]) in federal district court on June 7, 2022, that it was bypassing and abandoning the Board's *prerequisite* jurisdictional review process and the ensuing 30-day period for processing of the EJR request as specified in 42 C.F.R. § 405.1842 implementing 42 U.S.C. § 1395oo(f)(1).

If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid. For example, how is the Court to know that, subsequent to QRS filing the lawsuit to pursue the merits of the 4 CIRP group cases, QRS stated its intention to file a new EJR request and that the Board: (1) denied the original *consolidated* EJR request for all 4 CIRP group cases; (2) dismissed the no-pay Part A days issue from Case Nos. 14-2874GC and 14-3718GC; and (3) dismissed Case Nos. 14-2873GC and 14-3717GC? To further illustrate this very point, the Board has included at **Appendix A**, a non-exhaustive listing of some of the jurisdictional issues that the Board has identified thus far. The Board expects that additional, material, jurisdictional and/or claim filing issues would be identified if it were to complete the jurisdictional review process.

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[15] (Italics emphasis in original, and bold and underline emphasis added.)

[16] 42 C.F.R. § 405.1842(h)(3)(iii) ("*If* ***the lawsuit is filed*** *before a final EJR decision is issued on the legal question*, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved." (emphasis added)).

Board Findings:

The Board must consider the significant impact on the proceedings caused by QRS filing a federal lawsuit (merely 3 days after filing the June 4, 2022 *consolidated* EJR request) in connection with the above-referenced four (4) CIRP group cases.

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[17]

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

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal <u>if there is Board jurisdiction to conduct a hearing on the matter</u>** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).

[17] (Emphasis added.)

> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
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> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue** and a determination by the Board that it has no authority to decide the relevant legal question; or
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> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days <u>after finding jurisdiction</u> over the matter at issue <u>and</u> notifying the provider that the provider's EJR request is complete**.
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> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue <u>before</u> the Board may determine its authority to decide the legal question**.
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> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **<u>the 30-day period</u> for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **<u>does not begin to run until the Board finds jurisdiction to conduct a hearing</u> on the specific matter at issue in the EJR request <u>and</u> notifies the provider that the provider's request is complete**.[18]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[19] Moreover, the Board is bound by this regulation because, as

[18] (Emphasis added).

[19] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would <u>emphasize</u> that a***

stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[20]

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

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[21] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[22] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an

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

[20] (Emphasis added.)

[21] 42 U.S.C. § 1395oo(f)(1) (emphasis added).

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

> argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction*. EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
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> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[23]

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, could still prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[24] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 4 CIRP group cases,[25] the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. First, on July 22, 2022, before completing its jurisdictional review, the Board (1) denied the *consolidated* EJR request; (2) dismissed the no-pay Part A days issue from Case Nos. 14-2874GC and 14-3718GC as being abandoned; and (3) dismissed Case Nos. 14-2873GC and 14-3717GC because QRS' July 20, 2022 filing made it clear that they were not pursuing the DSH Medicaid fraction issue in those groups since QRS made clear it was only pursuing an "alternate

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

[24] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules. Indeed, ***subsequent to filing its Complaint on June 7, 2022***, QRS continued to expand the record and take actions in the Board proceedings in these group cases (*e.g.*, indicating in its July 20, 2022 correspondence with the Board that an updated EJR Request would be filed based on the Supreme Court's *Empire* decision) and it is unclear how a federal court is equipped to keep track of those actions and their import when there has been no jurisdictional determination and/or EJR decision in these cases.

[25] The Board dismissed 2 cases (*see supra* notes 1 and 2) and, to the extent those cases were remanded for reinstatement, then the Board would similarly need to complete the jurisdictional review process in these 2 cases.

issue" involving the DSH Medicare or SSI fraction. With respect to the 2 remaining groups under Case Nos. 14-2874GC and 14-3718GC, the Board stopped its jurisdictional review process after it learned that QRS had bypassed the completion of this process even before 30-days had elapsed. Having sufficient time to complete the jurisdictional and substantive claim review[26] process is vital to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns arise. Indeed, these concerns are very real and evident in these four (4) group cases as highlighted in **Appendix A**.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process *and* finds jurisdiction.[27] QRS' filing of the Complaint in federal district court ***3 days after the EJR Request was filed***, without notice to the Board or opposing party, is contemptuous of the Board's authority. It also demonstrates that QRS had no intention of allowing the Board to complete its jurisdictional review, much less the 30-day EJR review period to rule on the EJR request in these 4 CIRP group cases.

B. Effect of QRS' Concurrent Filing of the Lawsuit on the 4 CIRP Group Cases

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

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

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

[27] "Indeed, the statute and regulation by their terms do not impose *any* time constraints on the Board's determination of jurisdiction. *See* 42 U.S.C. 1395oo(f)(1); 42 CFR § 405.1842. The Hospitals' proffered interpretation of the regulation is so wildly disconnected from the text as to `warrant[] little attention.'" *St. Francis Medical Center, et al v. Xavier Becerra*, Memorandum Opinion, No. 1:22-cv-1960-RCL, at 8 (D.D.C. Sept. 27, 2023) (*citing Cape Cod Hosp. v. Leavitt*, 565 F. Supp. 2d 137, 141 (D.D.C. 2008)).

> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[28]

Thus, once "the lawsuit is filed", this regulation ***bars any further Board proceedings*** relating to the *consolidated* EJR request in these 4 group cases, including proceedings on *pre-requisite* jurisdictional issues or other procedural issues. As a result, the Board's June 22, 2022 denial of the *consolidated* EJR request for these 4 CIRP group cases, dismissal of the no-pay Part A issue from Case Nos. 14-2874GC and 14-3718GC, and the dismissal of Case Nos. 14-2873GC and 14-3717GC were void in the first instance; and as a result, the Board hereby rescinds those rulings in recognition of that fact. Further, consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring further action in these 4 group cases until, or if, the Administrator remands these cases back to the Board.

To confirm the proper application of § 405.1842(h)(3), the Board reviewed the preambles to the proposed rule, dated June 5, 2004,[29] and the May 23, 2008 final rule[30] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[31]

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

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues

[28] (Emphasis added.)
[29] 69 Fed. Reg. 35716 (June 25, 2004).
[30] 73 Fed. Reg. 30190 (May 23, 2008).
[31] 69 Fed. Reg. at 35732.

> jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. **We do not agree that it would be appropriate for the Board or the intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal**. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[32]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' concurrent filing of the lawsuit in the D.C. District Court on June 7, 2022 prohibits the Board from conducting any further proceedings on the *consolidated* EJR request for the 4 CIRP cases at issue therein as filed, including any proceedings related to the prerequisite jurisdiction and claims filing requirements. As such, the Board's July 22, 2022 determination denying the *consolidated* EJR requests, dismissing the no-pay Part A days issue from Case Nos. 14-2874GC and 14-3718GC, and dismissing Case Nos. 14-2873GC and 14-3717GC was void in the first instance and is hereby rescinded in recognition of this fact.

C. QRS' Actions

The Board finds that QRS' decision to withhold notice from the Board and the opposing parties of its filing of the federal district court lawsuit is tantamount to bad faith and actively created confusion surrounding the status of these cases at the Board because it ignored the 30-day Board review period as provided by 42 U.S.C. § 1395oo(f)(1) ***and*** *implemented at 42 C.F.R. § 405.1842*. Indeed, QRS' preemptive actions, taken without notice to the Board or the opposing parties, demonstrate that QRS had no intent to exhaust its administrative remedies before the Board. Pursuant to Board Rule 1.3

[32] 73 Fed. Reg at 30214-15 (bold and underline emphasis added).

(Nov. 1, 2022),[33] QRS had a duty to communicate early, and in good faith, with the Board and the opposing parties (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.

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

> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[34]

Indeed, the following acts (or inaction) by QRS reinforce the Board's finding that QRS has no basis to claim that proceedings before the Board have been exhausted:

1. QRS failed to notify the Board that, only 3 days after it filed the consolidated EJR request, it filed a lawsuit to bypass the Board's EJR review process and instead pursue the merits of the 4 CIRP group cases in federal court, notwithstanding the fact that the Board's EJR process is the only procedural process that allows the groups to bypass the Board's administrative review process.

2. QRS failed to promptly and timely notify the Board of its objection to the Board's ruling that the 30-day period to review the EJR request had not yet begun, and the associated Scheduling Orders for the 4 cases reaffirming that ruling. QRS' failure to file and preserve its objection to the Board's ruling and Scheduling Orders violates QRS' obligations under Board Rules 1.3, 5.2, and 44. QRS' failures further deprived the Board of an opportunity to reconsider its ruling and Scheduling Orders and, if necessary, correct or clarify that ruling and/or the Scheduling Orders.[35] It also resulted in the Board issuing, in error, its June 22, 2022 determination denying the June 4, EJR request and dismissing Case No. 14-2873GC and 14-3717GC because, had the Board known that a lawsuit had already been filed merely 3 days after the consolidated EJR request, then it would not have issued that determination consistent with 42 C.F.R. § 405.1842(h)(3)(iii).

3. QRS can make no claims that it was harmed by any delay caused by the Board's Scheduling Orders notifying QRS that the 30-day period to process the EJR request had not yet begun due to additional time needed for the Board to complete its jurisdictional

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

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

review when QRS filed a federal district court case ***merely 3 days after filing its EJR request.***

4. The Board made known to the parties in these cases its position regarding the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2).[36] Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period. The Board's notice was based on 42 C.F.R. § 405.1842(b)(2) which specifies that jurisdiction is a prerequisite to Board consideration of an EJR request ***and*** that the 30-day period to review the EJR request does ***not*** begin until the Board finds jurisdiction. To that end, the Board issued its Scheduling Order for these 4 CIRP group cases to memorialize, and effectuate, the necessity to conduct the jurisdictional review process and delay the start of the 30-day period to review the EJR request.[37] QRS failed to notify the Board of its objection to the Scheduling Orders. QRS' failure to timely file any objection violates Board Rules 1.3, 5.2 and 44. Indeed, QRS' actions interfered with the speedy, orderly and fair conduct of Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its rulings and, if necessary, correct or clarify them,[38] or take other actions, ***prior to*** QRS filing its June 7, 2022 Complaint. Indeed, QRS' preemptive actions did not even allow completion of the 30-day EJR review deadline, ***as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (and which QRS alleges in its litigation the Board missed)***, to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[39]

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the D.C. District Court violates Board Rule 1.3, and caused the Board and the Medicare Contractors to waste time and administrative resources when the Board was prohibited from taking any further action on the 4 CIRP group cases, pursuant to 42 C.F.R. § 405.1842(h)(3)(iii).

D. Board Actions

These facts demonstrate that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty." Indeed, QRS' failure to comply with Board Rule 1.3, through prompt notification of the lawsuit on, or about, June 4, 2022, prejudiced the Board, FSS and the Medicare Contractors. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay or cease work on these four (4) group cases and the underlying 22 participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS *and* by other representatives. Indeed, QRS' failure to ***timely*** notify the

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[36] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[37] *See supra* notes 6-8 and accompanying text.
[38] For example, the Board could have explained how reliance ***solely*** on 42 U.S.C. § 1395oo(f)(1) would be misplaced, given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 25, 2004 proposed rule. *See supra* notes 17-24 and accompanying text.
[39] *See supra* note 35 (discussing how the FRCP supports the Board's position).

Board, and the opposing parties, of this lawsuit filed in the D.C. District Court, raises very serious concerns about prejudicial sandbagging by QRS to benefit prior, current and subsequent EJR requests that QRS filed on behalf of other providers ***or*** by other representatives for EJR requests filed for the same issue.[40] The prejudicial sandbagging is highlighted by the facts that:

1. Across the 6-month period from December 20, 2021 to June 30, 2022, record concentrations of EJR requests were filed covering 642 group cases involving 2000+ participants (with the overlay of challenges caused by the surge in the Omicron variant of the COVID-19 virus at the beginning of that 6-month period); and

2. 80 percent of these requests were filed by either QRS or another representative, Healthcare Reimbursement Services ("HRS") (specifically QRS filed EJR requests covering 359 cases and HRS filed EJR requests covering 148 cases during this 6-month period).[41]

As a point of reference and context for these serious violations by QRS, the Board has included, at **Appendix C**, a copy of the closure letter it issued in 80 QRS cases that were included in a February 14, 2022 Federal Complaint in the California Central District Court. Finally, this is not an isolated event because it is the Board's understanding that: (1) QRS and HRS jointly filed the Complaint in the California Central District Court on April 20, 2022 establishing Case No. 22-cv-02648 covering 178 cases with 969 participants and did so without completing the jurisdictional review process, much less receiving the Board's jurisdictional decision, and without notice to the Board;[42] and (2) QRS filed at least one similar Complaint in the D.C. District Court on May 27, 2022 under Case No. 22-cv-01509.[43]

It is clear the Providers are pursuing the merits of their cases in these four (4) group cases as part of their lawsuit in the D.C. District Court.[44] Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[45]

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

[41] It is the Board's understanding that, on February 14, 2022, QRS established the initial ongoing litigation in the California Central District Court covering 80 group cases with 950+ participants in the aggregate, and that QRS and another representative, HRS *joined* the following additional cases to that lawsuit through the Amended Complaint filed on March 30, 2022 (without any notice to the Board or the opposing party). Similar litigation involving other EJR requests filed by QRS has been filed both in California and the District of Columbia. *See infra* notes 41 and 42 and accompanying text.

[42] Under separate cover, the Board closed the QRS cases by letters dated September 30, 2022 (Grouping A for Case Nos. 13-3842GC, *et al*.; Grouping B for Case Nos. 17-2150GC, *et al*.; and Grouping C for Case Nos. 18-0037GC, *et al*.) , and the HRS cases dated October 19, 2022 (Grouping A for Case Nos. 14-2400GC, *et al*.; and Grouping B for Case Nos. 15-055G, *et al*.). These closure letters included similar findings as in these QRS group cases.

[43] The Board has addressed the cases impacted by this litigation under separate cover.

[44] This is notwithstanding the Board's dismissal of 2 of these group cases.

[45] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by

However, the Board cannot permit QRS' reckless and contemptuous disregard for its ***basic*** responsibilities and due diligence as a representative appearing before the Board, its bypassing and abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, *if these cases are remanded back for further proceedings*, the Board may reinstate the July 22, 2022 determination and/or complete its jurisdictional review and weigh: (a) the severity of QRS' violations of, as well as failure to comply with, Board Rules, regulations and Orders; (b) the prejudice to the Board and the opposing parties; (c) the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others); and (d) the effect on the operations of the Board, when determining what, if any, remedial actions will be taken per 42 C.F.R. § 405.1868.[46] Examples of available remedial actions that the Board may consider taking in these 4 CIRP group cases[47] to defend its authority resulting from QRS' numerous, egregious regulatory violations and abuses include, but are not limited to:

1. Dismissal of the four (4) group cases and all underlying participants.

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

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

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[48] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board

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the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

[46] The Board's planned actions are consistent with those planned for QRS as laid out in **Appendix C**.

[47] As discussed in *supra*, the Board dismissed 2 cases on July 22, 2022. However, then unbeknownst to the Board, QRS had already initiated litigation in the D.C. District Court to pursue the merits on each of these 4 cases (including the 2 that the Board dismissed on July 22, 2022). To the extent the 2 cases that the Board dismissed were remanded back to the Board and reinstated, then the Board would consider remedial actions on these 2 cases.

[48] 42 C.F.R. § 405.1868 states:

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

(Emphasis added.)

> when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
>
> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[49]

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

E. Board Decision and Order

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

1. Rescinds the Board's July 22, 2022 determination denying the EJR request and dismissing Case Nos. 14-2873GC and 14-3717GC consistent with 42 C.F.R. § 405.1842(h)(3)(iii) because, on June 7, 2022, "the lawsuit [wa]s filed before a final EJR decision [wa]s issued on the legal question, [thus] the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved" and, accordingly, the Board's June 22, 2022 determination was void in the first instance.

2. Consistent with 42 C.F.R. § 405.1842(h)(3)(iii), closes the groups under Case No. 14-2874GC and 14-3718GC which remained open and affirms that the groups under Case Nos. 14-2873GC and 14-3717GC remain closed; and

[49] 73 Fed. Reg. at 30225.

3. Suspends the ongoing (or incomplete, as relevant) jurisdictional review process in these 4 CIRP group cases; and

4. Defers consideration of citing QRS for contempt and dismissing these 4 CIRP group cases (and/or taking other remedial action to uphold the authority of the Board) based on QRS' numerous, egregious, regulatory violations and abuses until there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[50]

Accordingly, the Board hereby affirms that the groups under Case Nos. 14-2873GC and 14-3717GC remain closed and then closes the groups under Case No. 14-2874GC and 14-3718GC and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

3/25/2024

X Clayton J. Nix

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

Enclosures:
Appendix A –Interim List of Potential Jurisdictional & Procedural Violations Under Review
Appendix B – June 10, 2022 Board Letter to QRS Deferring Show Cause Order & Closure of Cases

cc: Michael Redman, Novitas
Wilson Leong, FSS
Jacqueline Vaughn, OAA

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

APPENDIX A

INTERIM LIST OF POTENTIAL JURISDICTIONAL, SUBSTANTIVE CLAIM, AND PROCEDURAL VIOLATIONS UNDER REVIEW[51]

The following summary of jurisdictional, substantive claim and procedural concerns and issues is preliminary and highlights the complexity of the jurisdictional review process.[52] This process is *exponentially* more complex when consolidated EJR requests are concurrently filed involving multiple group cases with 36 participants and when many of those cases are older cases (7+ years old).

The Board, through its ongoing review of jurisdiction, and other procedural issues, in these 4 CIRP group cases, has identified multiple, ***material*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The Board notes that: (1) in dismissing Case Nos. 14-2873GC and 14_3717GC, the Board had not yet completed its jurisdictional review process and that process would still be ongoing upon the recission of the Board's July 22, 2022 determination; and (2) the Board has not completed its jurisdictional review process in Case Nos. 14-2874GC and 14-3718GC due to QRS' August 31, 2022 notice of the lawsuit.

The Board's jurisdictional review is based on the Schedules of Providers ("SoPs") filed for these cases because, as explained at Board Rule 20.1.1 (Nov. 2021),[53] the SoP is supposed to contain all relevant jurisdictional documentation for each participant in the group. The issues and concerns identified by the Board (thus far) include, but are not limited to, the following:

1. *Invalid Appeals Due to Failure to Timely Appeal or Provide the Requisite Documentation*.— QRS failed to include sufficient documentation in the SoPs to establish that some of the participants filed timely appeals. As a result, the Board is reviewing dismissal of several of the participants for failure to meet the claims filing requirements. For appeals based on an NPR, 42 C.F.R. § 405.1835 requires providers to file their appeals within 180 days of receipt of the final determination where the "date of receipt" is defined in § 405.1801 "to be presumed to be 5 days after the date of issuance."[54] However, there as situations where QRS failed to establish such a timely filing in the final SoP submitted for these 4 CIRP groups. For example, in Case Nos. 14-3717GC and 14-3718GC, Participant No. 5 (Hillcrest Hospital South of Tulsa, OK) filed its appeal one day late based on the documentation submitted.[55]

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[51] This listing is not exhaustive and only reflects preliminary findings and the Board has not yet completed or finalized its jurisdictional findings in these 4 group cases.

[52] The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claim filing requirements such as timelines or filing deadlines. For example, whether an appeal was timely is not a jurisdictional requirement but rather is a claim filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013). *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*. Similarly, the Board notes that 42 C.F.R. §§ 405.1835(b) and 405.1837(c) address certain claim filing requirements.

[53] *See also* Board Rule 20.1 (Aug. 2018).

[54] The regulation also states that the "presumption, which is otherwise conclusive, may be overcome if it is established by a preponderance of the evidence that such materials were actually received on a later date." However, QRS did not submit such other evidence with any of the participants in the final SoPs for these 4 CIRP groups.

[55] The documentation included in the SoPs for Case Nos. 14-3717GC and 14-3718GC establishes that the NPR appealed for this participant is dated August 15, 2014. As a result, the participant's appeal was due to the Board by

Similarly, in Case Nos. 14-2873GC and 14-2874GC, QRS asserts that: (1) the Participant No. 4 (Hillcrest Hospital Cushing of Henryetta, GA) was directly added on September 19, 2014 to these CIRP groups; and (2) in lieu of the requisite proof of delivery required under Board Rules 4.3 and 21(B)(2) (2015),[56] the Board's consolidation letter dated December 29, 2015 "references receipt of the Model Form B using this provider." However, the Board's consolidation letter only references a "letter dated September 19, 2014" and does not state when such letter was actually received. As such, that letter alone cannot establish timely filing.

2. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— A significant number of the participants in the 4 CIRP group cases arrived by transfer from an individual provider appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[57] The Board expects it may identify multiple participants with these types of jurisdictional transfer issues if it were to complete its jurisdictional review.

3. *Failure to Document Compliance with the Minimum Amount in Controversy ("AiC") for a Group Appeal*.— As explained in 42 C.F.R. § 405.1839(b): "[i]n order to satisfy the amount in controversy ["AiC"] requirement . . . for a Board hearing as a group appeal, the group must demonstrate that if its appeal were successful, the total program reimbursement for the cost reporting periods under appeal would increase, in the aggregate, by at least $50,000."[58] Further, it explains that, "[f]or purposes of satisfying the amount in controversy requirement, group members are not allowed to aggregate claims involving different issues" because "[a] group appeal must involve a single question of fact or interpretation of law, regulations, or CMS Ruling that is common to each provider . . . ." In both Case Nos. 14-2874GC and 14-3718GC involving the DSH SSI fraction, the Board is reviewing the AiC calculation behind Tab E of the relevant SoP because most of the participants failed to have an AiC calculation behind that Tab that pertains to the group issue (rather, the AiC calculation pertains only to the

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Monday, February 16, 2015 (180 days plus 5 days). However, as Monday February 16, 2015 was a federal holiday, the deadline was extended to the next business day, Tuesday, February 17, 2015. However, the documentation included in the SoPs for Case Nos. 14-3717GC and 14-3718GC shows that the participant filed its appeal one day late on February 17, 2015.

[56] In particular, Board Rule 4.3 (2015) states that "It is the responsibility of the Provider to maintain record of delivery." Similarly, Board Rule 21(B)(2) pertains to the documentation required in the SoP and specifies "[i]f the appeal request was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue. *[March 2013]*"

[57] The window to add issues to an individual appeal is limited by the regulation at 42 C.F.R. § 405.1835(e) as follows: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. §§ 405.1835(b), 1837(c), & Board Rule 8 for content and specificity requirements for issues being appealed.

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

DSH Medicaid fraction, a separate and distinct issue[59]). As a result, each of these groups would fail to meet the minimum $50,000 AiC requirement for a valid and proper group as it relates to the group issue (*i.e.*, the DSH SSI fraction issue seeking to exclude no-pay Part A days from the DSH SSI fraction).[60]

4. *Reviewing Scope of the EJR Request and Potential Improper Groups*.—In order for the Board to have jurisdiction over a group appeal, the group appeal must contain only one legal question/issue.[61] Pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1837(a)(1), a group may only contain one legal issue. In pertinent part, § 405.1837(a)(1) states that "[a] provider . . . has a right to a Board hearing, as part of a

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[59] Consistent with the Board's application of the requirement that a group may contain only "a single question of . . . interpretation of law, regulations, or CMS Rulings that is common to each provider in the group," the Board has a long history of treating appeals seeking the exclusion of no-pay Part A days from the SSI fraction as a separate legal issue from appeals seeking the inclusion of no-pay Part A days involving dual eligibles in the numerator of the Medicaid fraction since the policy in effect prior to the FY 2005 IPPS Final Rule excluded no-pay Part A days from both the Medicare and Medicaid fractions (*see* CMS Ruling 1498-R at 7-6; CMS Ruling 1498-R2 at 3) and the invalidation of the current policy would result in reinstatement to that prior policy (*see Empire Health Found. v. Azar*, 958 F.3d 873 (9th Cir. 2020) ("reinstat[ing] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force), *reversed*, *Becerra v. Empire Health Found.*, No 20-1312, 2022 WL 2276810 (S.Ct. June 24, 2022). To this end, the Providers filed and maintained separate groups for the DSH SSI fraction issue under Case Nos. 14-2873GC and 14-3717GC from the DSH Medicaid fraction issue under Case Nos. 14-3874GC and 14-3718GC.

[60] In Case No. 14-2873GC, the SoP has AiCs behind Tab E for Participants Nos. 1 and 2 only pertain to the DSH Medicaid fraction. Excluding the AiC for these 2 participants results in an AiC of only $18,983 which falls well below the minimum $50,000 threshold (Participants 3 through 5 have AiCs of $11,534, $3,828, $3,621). Similarly, in Case No. 14-3718GC, the SoP has AiCs behind Tab E for Participants Nos. 3 to 6 only pertain to the DSH Medicaid fraction. Excluding the AiC for these 4 participants would result in an AiC of only $48,696 which falls well below the minimum $50,000 threshold (Participants 1 and 2 have AiCs of $41,129 and $7,567). Regardless, the Board also questions whether the AiCs for Participants 1 and 2 in Case No. 14-3718GC is a good faith estimate because it does not describe how the AiC was calculate but rather simply states the AiC in compliance with 42 C.F.R. § 405.1839(b). *See also* 42 C.F.R. § 405.1837(c) (specifying among other things that the content of a group appeal request must including the following: "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." (emphasis added)).

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

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

> group appeal with other providers, with respect to a final contractor or Secretary determination for the provider's cost reporting period, ***only if*** - . . . (2) The matter at issue in the group appeal involves ***a single*** question of fact or ***interpretation*** *of law, regulations, or CMS Rulings* that is common to each provider in the group.[62] Consistent with QRS' August 31, 2022 letter, the Board is reviewing whether the Providers' consolidated EJR requests are ***improperly*** challenging *multiple* interpretations of law or regulation. In particular, the Board is reviewing whether the EJR request properly includes a challenge to the SSI eligibility codes used to identify the SSI days to be included in the numerator of the Medicare fraction (as embodied in PRRB Dec. No. 2017-D11[63]) in addition to the no-pay Part A days issue (as embodied in the *Empire* litigation decided before the Supreme Court[64]). If true, it raises ***immediate*** jurisdictional problems of whether the additional challenge(s) are *properly* part of the relevant groups[65] and, if true, requires determining: (1) whether each of the participants properly appealed additional issues[66] and, as relevant, whether it requested transfer of those additional issues to the group; (2) if a preliminary position paper was filed, whether the additional was properly briefed in the preliminary position paper in compliance with 42 C.F.R. § 405.1853(b)(2) and Board Rule 25[67]; and (3) whether the additional issues should be bifurcated from the group per 42 C.F.R. § 405.1837(f)(2). A critical aspect of the jurisdictional inquiry entails confirming that any potential bifurcation would not result in prohibited duplicate appeals by the same providers for the same issue and years. The Board has already flagged this issue in its letter dated July 22, 2022 and it was in the QRS' response to this inquiry that the Board learned of the litigation that QRS filed bypassing completion of the Board's administrative review process.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, with the June 7, 2022 filing of the Complaint in federal district court, that it was bypassing and abandoning the Board's jurisdictional review process (as discussed above).

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[62] (Emphasis added.)
[63] *Hall Render Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D11 (Mar. 27, 2017).
[64] *Becerra v. Empire Health Found.*, 142 S. Ct. 2354 (2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).
[65] This includes whether the group appeal request includes the additional issue and whether the final SoP filed in the relevant group establishes that the group meets the $50,000 AiC requirement for each of the additional issues. Per 42 C.F.R. § 405.1839(b), participants in a group are ***not*** permitted to aggregate claims involving different issues for purposes of meeting the $50,000 AiC requirement.
[66] Note that a proper appeal on an issue must include an AiC calculation for that issue. If the Providers were to claim that the group had multiple issues, then each participant would have a separate AiC calculation in the SoP *for* ***each*** *issue*. *See* 42 C.F.R. §§ 405.1839(b), 405.1837(c)(2)(iii). However, the Board's initial impressions are that each participant generally only has ***one*** AiC calculation behind Tab E in the relevant SoP.
[67] 42 C.F.R. § 405.1853(b)(2) and Board Rule 25 require the full briefing of each issue in a position paper filing. Consistent with this regulation and Board Rule 25, Board Rule 25.3 specifies that "[i]f the provider fails to brief an appealed issue in it is position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Cases where the Providers' preliminary position paper was filed prior to the relevant consolidated EJR request being filed include:

APPENDIX B

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

(35 pages)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Dear Mr. Berends and Ravindran:

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

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

[2] *See supra* note 1.

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

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

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

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

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

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

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

Procedural Background

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

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

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

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

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

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[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

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

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

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

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

[17] (Emphasis in original.)

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

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

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

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

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

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

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[18] *See supra* note 3.

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

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

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

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

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

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

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

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

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

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

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

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

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

Board Findings and Ruling:

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

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

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

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. *Prohibited Duplicate Appeals*

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

2. *Providers With No Appeal Rights*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Prohibited Participation of CIRP Providers in Optional Groups

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

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

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

5. *Unauthorized Representation of Participants*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[74]

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

[93] 42 C.F.R. § 405.1868 states:

(a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take *appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal*.

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(Emphasis added.)

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

* * * * *

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

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
Judith Cummings, CGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
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Wilson Leong, FSS
Jacqueline Vaughn, OAA

[94] 73 Fed. Reg. at 30225.
[95] *See supra* note 92.

LIST OF 80 GROUP CASES

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***Notice of Dismissal of Part C Appeals Based on June 9, 2023 Final Rule***
Case No. 24-0219GC, *et al.* (*see* **Appendix A** listing 32 cases)

Dear Ms. Mogden:

The Provider Reimbursement Review Board ("Board") has reviewed the appeal requests filed by the Providers in the thirty-two (32) above-referenced common issue related party ("CIRP") and optional group cases. Set forth below is the decision of the Board to dismiss these thirty-two (32) appeals challenging the treatment of Medicare Part C Days in the disproportionate share hospital ("DSH") adjustment calculation from the final rule published on June 9, 2023 entitled "Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage" (hereinafter the "June 2023 Final Rule").[1]

Background:

Hall, Render, Killian, Heath & Lyman, P.C. ("Hall Render") represents a number of Providers in CIRP and optional group cases which are challenging the treatment of Medicare Part C Days in the DSH adjustment calculation as appealed from the June 2023 Final Rule. Between November 18, 2023 and December 6, 2023, Hall Render initiated these appeals by filing appeal requests on behalf of 32 different CIRP and optional groups concerning the June 2023 Final Rule that the Secretary of Health and Human Services ("Secretary") published as it relates to the those providers' Medicare disproportionate share hospital ("DSH") adjustment calculation and attached to these appeal requests a PDF copy of that Final Rule labeled as "Final Determination Document."[2]

In the June 2023 Final Rule, the Secretary adopted and finalized *its policy* to include Part C days in the SSI fraction as used in the DSH adjustment calculation for Part C discharges occurring *prior to* October 1, 2013 and applied this policy *retroactively* to certain open fiscal years to which this policy would appeal.

The Providers in the group appeals all pertain to multiple fiscal years. The ***sole*** issue in each of these appeals is "whether Part C days are properly included in the denominator of the Medicare

[1] 88 Fed. Reg. 37772 (June 9, 2023).
[2] *Id.*

Fraction per a June 9, 2023, retroactive final rule issued by the Centers for Medicare & Medicaid Services ("CMS"), which is binding on the Medicare Administrative Contractor ("MAC"), or whether such final rule is illegal and cannot be enforced."[3] Thus, the Hall Render Providers challenge the procedural and substantive validity of the policy adopted and finalized in the June 2023 Final Rule.[4] To that end, the appeal requests identify the June 2023 Final Rule as the "final determination" being appealed and also included a PDF copy of that Final Rule with the label "Final Determination Document." *Significantly,* ***none of the appeals*** *included a copy of alleged "accompanying SSI ratios—as to the DSH payment amount they will receive for the fiscal years at issue*."[5]

The Providers' appeal requests have not provided ***any*** explanation in their appeal requests of why the Board has jurisdiction over their appeal of the June 2023 Final Rule and *none has specifically demonstrated that the Final Rule is,* ***in fact, applicable to them***. In this regard, the appeal requests do not include ***any*** *NPR or revised NPR in their appeal requests* (to document their eligibility for a DSH adjustment for the relevant fiscal year) or documentation of any CMS Ruling 1739-R remands from prior appeals of the DSH Part C days issue for the same year. As explained below, it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

Issue in Dispute:

Hall Render is the group representative for these 32 cases filed between November 18, 2023 and December 6, 2023. Each case has the same material issue statement, which states the issue is:

> *Providers challenge CMS's Final Rule*, titled MEDICARE PROGRAM: TREATMENT OF MEDICARE PART C DAYS IN THE CALCULATION OF A HOSPITAL'S MEDICARE DISPROPORTIONATE PATIENT PERCENTAGE, 88 Fed. Reg. 37,772 (June 9, 2023), *effected through supplemental security income (SSI) ratios re-published by CMS and applicable to the Providers*. The Final Rule retroactively implements a change in policy governing CMS's treatment of Medicare Part C Days in the calculation of the Providers' disproportionate share hospital (DSH) adjustments prior to October 1, 2013. The Rule changes CMS's prior policy of including Part C Days in the Medicaid Fraction and excluding these days from the Medicare Fraction of the Disproportionate Patient Percentage (DPP). Now, CMS seeks to retroactively reverse course and include Part C Days in the Medicare Fraction of the DPP.

[3] Issue Statement at 1 in Case No. 24-0219GC. Each of the Issue Statements in the 32 Hall Render appeals referenced in this decision are materially identical.
[4] 88 Fed. Reg. 37772 (June 9, 2023).
[5] Issue Statement at 1 in Case No. 24-0219GC (emphasis added).

> **The issue in this appeal is whether the Final Rule,[6] which retroactively applies a change in policy to include Part C Days in the Medicare Fraction and exclude these days from the Medicaid Fraction, is substantively invalid, procedurally invalid, or both.**
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> *Providers therefore appeal the Secretary's final determination—contained in the Final Rule and the accompanying SSI ratios*—as to the DSH payment amount they will receive for the fiscal years at issue.[7]

In referencing the published SSI ratios, Hall Render included a footnote containing the following information about those SSI ratios:

> CMS 1739-F SSI Ratios, available at: https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/disproportionate-share-hospital-dsh (last accessed Nov. 15, 2023).

The link is to a CMS webpage entitled "Disproportionate Share Hospital (DSH)" and, as of March 25, 2024, includes notice that "Page Last Modified: 03/13/2024 09:29 AM."

Statutory and Regulatory Background:

A. Medicare DSH Payment

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under the inpatient prospective payment system ("IPPS").[8] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[9]

The IPPS statute contains several provisions that adjust reimbursement based on hospital-specific factors.[10] This case involves the hospital-specific DSH adjustment, which requires the Secretary to provide increased IPPS payments to hospitals that serve a significantly disproportionate number of low-income patients.[11]

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[6] Referencing Medicare Program; Treatment of Medicare Part C Days in the Calculation of a Hospital's Medicare Disproportionate Patient Percentage, 88 Fed. Reg. 37,772 (June 9, 2023).
[7] Issue Statement at 1 in Case No. 24-0219GC (footnotes omitted, bold emphasis in original, and underline and italics emphasis added). Each of the Issue Statements in the 32 Hall Render appeals referenced in this decision are materially identical.
[8] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[9] *Id.*
[10] *See* 42 U.S.C. § 1395ww(d)(5).
[11] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[12] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[13] The DPP is defined as the sum of two fractions expressed as percentages.[14] Those two fractions are referred to as the "Medicare/SSI fraction" and the "Medicaid fraction." Both of these fractions consider whether a patient was "entitled to benefits under part A."

The statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I) defines the Medicare/SSI fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of such hospital's patient days for such period which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter and were entitled to supplemental security income benefits (excluding any State supplementation) under subchapter XVI of this chapter, and the denominator of which is the number of such hospital's patient days for such fiscal year which were made up of patients who (for such days) were ***entitled to benefits under part A*** of this subchapter . . . .[15]

The Medicare/SSI fraction is computed annually by the Centers for Medicare and Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute a hospital's DSH payment adjustment.[16]

The statute, 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), defines the Medicaid fraction as:

> the fraction (expressed as a percentage), the numerator of which is the number of the hospital's patient days for such period which consist of patients who (for such days) were eligible for medical assistance under a State plan approved under subchapter XIX [the Medicaid program], but who were ***not entitled to benefits under part A of this subchapter,*** and the denominator of which is the total number of the hospital's patient days for such period.[17]

The Medicare contractor determines the number of the hospital's patient days of service for which patients were eligible for Medicaid but not entitled to Medicare Part A and divides that number by the total number of patient days in the same period.[18]

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[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[13] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[15] (Emphasis added.)
[16] 42 C.F.R. § 412.106(b)(2)-(3).
[17] (Emphasis added.)
[18] 42 C.F.R. § 412.106(b)(4).

B. Establishment of Medicare Part C and Treatment of Part C Days in the DSH Calculation

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[19] 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].[20]

At that time Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[21]

With the creation of Medicare Part C in 1997,[22] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C

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[19] of Health and Human Services.
[20] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[21] *Id.*
[22] 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. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.

days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[23]

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 . . . .*[24]

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."[25] 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.*[26]

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

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

[23] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).
[24] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[25] 69 Fed. Reg. at 49099.
[26] *Id.* (emphasis added).

August 22, 2007, when the FFY 2008 IPPS final rule was issued.[27] 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).[28] 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, the Secretary 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."[29]

There has been substantial litigation over whether enrollees in Part C plans are "entitled to benefits" under Medicare Part A when determining their placement in either the DSH Medicare or Medicaid fraction.

First, in 2011, the D.C. Circuit held that the Secretary's Part C policy in the FY 2005 IPPS Final Rule could not be applied retroactively for fiscal years 1999 through 2002, but did not address whether it could be applied to later years or whether the interpretation was reasonable.[30]
In 2014, the U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[31] 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.[32] In vacating the final rule, it reasoned that this deprived the public of adequate opportunity for notice and comment before the final rule was promulgated in 2004.[33] However, the Secretary has not acquiesced to that decision.

In 2013, the Secretary promulgated a new rule that would include Part C days in the Medicare fraction for fiscal years 2014 and beyond.[34] However, at that point, no new rule had been adopted for fiscal years 2004-2013 following the D.C. Circuit's decision in *Allina I* to vacate the 2004 rule. In 2014 the Secretary published Medicare fractions for fiscal year 2012 which included Part C days.[35] A number of hospitals appealed this action. In *Azar v. Allina Health*

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[27] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[28] *Id*. at 47411.
[29] 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).
[30] *Northeast Hosp. Corp. v. Sebelius*, 657 F.3d 1, 17 (D.C. Cir. 2011).
[31] 746 F. 3d 1102 (D.C. Cir. 2014).
[32] *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.").
[33] *Id.* at 2011.
[34] 78 Fed. Reg. 50496, 50614 (Aug. 19, 2013).
[35] *See Allina Health Services v. Price*, 863 F.3d 937, 939-940 (D.C. Cir. 2017).

Services ("*Allina II*"),[36] the Supreme Court held that the Secretary did not undertake appropriate notice-and-comment rulemaking when it applied its policy to fiscal year 2012, despite having no formal rule in place.[37] There was no rule to vacate in this instance, and the Supreme Court merely affirmed the D.C. Circuit's decision to remand the case "for proceedings consistent with [its] opinion."[38] The Supreme Court did not reach the question of whether the policy to count Part C days in the Medicare fraction was impermissible or unreasonable.[39]

On August 6, 2020, the Secretary published a notice of proposed rulemaking to adopt a policy to include Part C days in the Medicare fraction for fiscal years prior to 2013.[40] On August 17, 2020, CMS issued CMS Ruling 1739-R stating that, as "CMS has announced its intention to conduct the rulemaking required by the Supreme Court's decision in Allina [II]":

> This Ruling provides notice that the Provider Reimbursement Review Board (PRRB) and other Medicare administrative appeals tribunals lack jurisdiction over certain provider appeals regarding the treatment of patient days associated with patients enrolled in Medicare Advantage plans in the Medicare and Medicaid fractions of the disproportionate patient percentage; this ruling applies only to appeals regarding patient days with discharge dates before October 1, 2013 that arise from Notices of Program Reimbursement (NPRs) that are issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013 or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule.[41]

The Secretary did not change the proposed rule and issued it in final on June 9, 2023.[42] The June 2023 Final Rule provides the following guidance on the extent to which it is to be applied *retroactively*:

> [T]he Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled***, encompassing thousands of cost reports.[43]

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[36] 139 S. Ct. 1804 (2019).
[37] *Id.* at 1817.
[38] *Id.*; *Allina Health Services v. Price*, 863 F.3d at 945.
[39] 139 S. Ct at 1814.
[40] 85 Fed. Reg. 47723 (Aug. 6, 2020).
[41] CMS Ruling 1739-R at 1-2.
[42] 88 Fed. Reg. 37772 (June 9, 2023).
[43] *Id.* at 37775 (emphasis added).

Further, the June 2023 Final Rule provided the following clarification on the intent and purpose of CMS Ruling 1739-R:

> The Ruling was not intended to cut off appeal rights and will not operate to do so. It was intended to promote judicial economy by announcing HHS's response to the Supreme Court's decision in *Allina II*. After the Supreme Court made clear that CMS could not resolve the avowedly gap-filling issue of whether Part C enrollees are or are not "entitled to benefits under part A" for years before FY 2014 without rulemaking, HHS issued the Ruling [1739-R] so that providers would not need to continue litigating over DPP fractions that were issued in the absence of a valid rule. In other words, the point of the Ruling was to avoid wasting judicial, provider, and agency resources on cases in which the Secretary agreed that, after the Supreme Court's decision in *Allina II*, he could not defend such appeals of fractions issued in the absence of a valid regulation.[44]

Decision of the Board:

As set forth below, the Board hereby ***dismisses*** the Providers' appeals because: (1) they failed to appeal from a "final determination" as that term is used in 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 1835(a) (as also cross-referenced in 42 C.F.R. § 405.1837(a)(1)) and ; and (2) *to the extent the June 2023 Final Rule is* ***in fact*** *applicable to them*, their appeals are premature and their appeal requests failed to meet the content requirements for a request for Board hearing as a group appeal.

A. The Part C Policy finalized in the June 2023 Final Rule Is Not an Appealable "Final Determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii).

In filing these group appeals, the Providers identified the June 2023 Final Rule as the "final determination" being appealed and, to that end, attached a PDF copy of that Final Rule labeled as "Final Determination Document." As this is a final rule (as opposed to an NPR or revised NPR), they appear to be asserting that their right to appeal is based on 42 U.S.C. § 1395oo(a)(1)(A)(ii). In this regard, § 1395oo(a) the following in pertinent part:

> **(a) Establishment**
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> . . . *[A]ny hospital* which receives payments in amounts computed under subsection (b) or (d) of section 1395ww of this title *and which has submitted such [cost] reports within such time as the Secretary may require in order to make payment under such*

[44] 88 Fed. Reg. at 37788 (emphasis in original).

> *section* may obtain a hearing with respect to such payment by the Board, if—
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> (1) such provider—
>
> (A) . . .
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> (ii) is dissatisfied with a final determination of the Secretary *as to the amount of the payment* under subsection (b) or (d) of section 1395ww of this title, ...[45]

However, the Board finds that the adoption/finalization of this policy in the June 2023 Final Rule is not a "final determination" directly appealable to the Board *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*. Rather, the providers' appeals are premature as described below.

Unlike DRG rates and other adjustments such as the wage index, a hospital's eligibility for a DSH payment (and, if eligible, the amount of that payment) during a particular fiscal year is not ***prospectively*** set or determined as part of the relevant IPPS final rule. In this regard, 42 U.S.C. § 1395ww(d)(5)(F) refers to the DSH adjustment being calculated "with respect to a [hospital's] cost reporting period" and uses days associated with inpatients stays *occurring during that cost reporting period*.[46] To this end, DSH eligibility ***and*** payment, if any, is determined, calculated, and finalized *annually* through the cost report audit/settlement process as made clear in 42 C.F.R. § 412.106(i) which sets forth the following instructions regarding the determination of a hospital's eligibility for a DSH payment for each fiscal year and, if so, how much:

> (i) *Manner and timing of [DSH] payments*. (1) **Interim** [DSH] **payments** are made **during the payment year to each hospital that is estimated to be eligible** for payments under this section at the time of the annual final rule for the hospital inpatient prospective payment system, **subject to the final determination of eligibility at the time of cost report settlement for each hospital**.
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> (2) **Final payment determinations are made at the time of cost report settlement**, based on the **final** determination of each hospital's eligibility for payment under this section.[47]

The Secretary makes clear that this regulation is based on "our ***longstanding*** *process* of making ***interim*** *eligibility* determinations for Medicare DSH payments *with* ***final*** *determination* ***at cost***

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[45] (Bold emphasis in original and italics and underline emphasis added.)
[46] The Board notes that the Medicare DSH adjustment provision under 42 U.S.C. § 1395ww(d)(5)(F) was enacted by § 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") and became effective for discharges occurring on or after May 1, 1986. Pub. L. 99-272, § 9105, 100 Stat. 82, 158-60. As such, it was enacted several years after the initial legislation that established the IPPS.
[47] (Italics emphasis in original and bold and underline emphasis added.) This section was added as part of the FY 2014 IPPS Final Rule. 78 Fed. Reg. 50496, 50646, (Aug. 19, 2013). It was initially codified at § 412.106(h) (*id.*), but was later redesignated as § 412.106(i) (87 Fed. Reg. 48780, 49049 (Aug. 10, 2022)).

report settlement."[48] Examples of other adjustments to IPPS payment rates that are based, in whole or in part, on certain data/costs claimed on the as-filed cost report and then determined

[48] 78 Fed. Reg. at 50627. *See also* Provider Reimbursement Manual, CMS Pub. 15-1 ("PRM 15-1"), § 2807.2(B)(5) (last revised Aug. 1993, Transmittal 371) (stating: "*At* ***final*** ***settlement*** *of the cost report*, the intermediary determines the final disproportionate share adjustment based on the actual bed size and disproportionate share patient percentage for the cost reporting period." (emphasis added)). In the preamble to the FY 2014 IPPS Final Rule, the Secretary discussed the DSH eligibility and payment process and the following are excerpts from that discussion:

> *Comment*: Several commenters requested that CMS undertake additional audits to verify the data used to compute the 25-percent empirically justified Medicare DSH payment adjustments. Other commenters requested that CMS grant additional time for hospitals to verify the data and adjust their cost reports to ensure that the data used to compute the adjustment are accurate and up to date. Some commenters requested that CMS establish procedures to allow a hospital initially determined not to be eligible for Medicare DSH payments to begin receiving empirically justified Medicare DSH payments if data become available that indicate that the hospital would be eligible.
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> *Response*: As we have emphasized, we are maintaining the well-established methodology and payment processes used under the current Medicare DSH payment adjustment methodology for purposes of making the empirically justified Medicare DSH payment adjustments. Hospitals are quite familiar with the cost reporting requirements and auditing procedures employed under the current Medicare DSH payment adjustment methodology. Hospitals are also familiar with the current process of determining **interim eligibility** for Medicare DSH payments **with final determination at cost report settlement**. Therefore, we do not believe that it would be warranted to add additional complexity to these procedures by adopting any of these recommendations.
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> **For the reasons discussed above regarding the empirically justified Medicare DSH payments** [*i.e.*, the DSH payment calculation made under 42 U.S.C. § 1395ww(d)(5)(F)], **we do not believe that it is necessary or advisable to depart from our longstanding process of making interim eligibility determinations for Medicare DSH payments with final determination at cost report settlement.** As we discuss in greater detail in section V.E.3.f. of the preamble to this final rule, we will make interim eligibility determinations based on data from the most recently available SSI ratios and Medicaid fractions prior to the beginning of the payment year. We will then make final determinations of eligibility at the time of settlement of each hospital's cost report. Therefore, we proposed that, at cost report settlement, the fiscal intermediary/MAC will issue a notice of program reimbursement that includes a determination concerning whether each hospital is eligible for empirically justified Medicare DSH payments and, therefore, eligible for uncompensated care payments in FY 2014 and each subsequent year. In the case where a hospital received interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year on the basis of estimates prior to the payment year, but is determined to be ineligible for the empirically justified Medicare DSH payment at cost report settlement, the hospital would no longer be eligible for either payment and CMS would recoup those monies. For a hospital that did not receive interim payments for its empirically justified Medicare DSH payments and uncompensated care payments for FY 2014 or a subsequent year, but at cost report settlement is determined to be eligible for DSH payments, the uncompensated care payment for such a hospital is calculated based on the Factor 3 value determined prospectively for that fiscal year.

Id. at 50626-27 (emphasis added).

and reimbursed through the cost report audit and settlement process include bad debts,[49] direct graduate medical education ("GME"),[50] and indirect GME.[51]

Here, none of the Providers' appeal requests included a copy of the NPR or revised NPR (with associated audit adjustment pages) for the year at issue that would underlie the alleged pending remand to the MACs. As a result, it is unclear whether that those NPRs/revised NPRs addressed consistent with 42 C.F.R. § 412.106(i) both: (1) whether each of these Providers is eligible for a DSH payment *for the relevant year at issue*; and (2) if so, how much.[52]

The four corners of the June 2023 Final Rule confirms that the Providers appeals are premature because the June 2023 Final Rule confirms both that: (1) it is ***not*** a final determination appealable to the Board; *and* (2) the Secretary did ***not*** otherwise intend for it to be a final determination appealable to the Board. The June 2023 Final Rule simply finalizes the adoption of the Part C days policy at issue but only for certain *open* cost reporting periods relating to discharges occurring prior to October 1, 2013. It does not make any determination on *any* hospital's DSH eligibility (much less these Providers') and, if so, how much. Moreover, it does not publish *any* hospital's SSI percentage (much less these Providers for the relevant years at issue) that would be used in DSH calculations for those hospitals whose eligibility would later be determined as part of their cost report settlement process for the relevant fiscal years. Further, the following excerpts from the June 2023 Final Rule discussing a hospital's right to challenge the Part C days policy adopted therein make clear that the Secretary did not consider the final rule to be an appealable "final determination":

1. "Additionally, the Secretary has determined that it is in the public interest for CMS to adopt a retroactive policy for the treatment of MA patient days in the Medicare and Medicaid fractions through notice and comment rulemaking for discharges before October 1, 2013 (the effective date of the FY 2014 IPPS final rule). *CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals* ***whose DSH payments for those periods are still open or have not yet been finally settled, encompassing thousands of cost reports****. In order to calculate these payments, CMS* ***must*** *establish Medicare fractions for* ***each***

[49] 42 C.F.R. §§ 412.2(f)(4), 412.115(a) (stating: "An additional payment is made to each hospital in accordance with § 413.89 of this chapter for bad debts attributable to deductible and coinsurance amounts related to covered services received by beneficiaries.).
[50] 42 C.F.R. § 412.2(f)(7) (stating that hospitals receive an additional payment for "[t]he direct graduate medical education costs for approved residency programs in medicine, osteopathy, dentistry, and podiatry as described in §§413.75–413.83 of this chapter.").
[51] 42 C.F.R. §§ 412.2(f)(2), 412.105. *See also* PRM 15-1 § 2807.2(B)(6) (stating: "*At* ***final settlement*** *of the cost report*, the intermediary determines the indirect teaching adjustment based on the actual number of full time equivalent residents and average daily census for the cost reporting period. (emphasis added)).
[52] In this regard, a provider that did not qualify for a DSH payment adjustment for a particular fiscal year may appeal that finding by challenging multiple components of the DSH adjustment calculation which, if successful, could result in the provider qualifying for a DSH adjustment for that year. Further, the fact that a hospital has received a DSH payment in a ***prior*** fiscal year, does not mean or guarantee that the hospital will (or continue to) be eligible for and receive a DSH payment in a subsequent fiscal year. For each fiscal year, the Medicare contractor determines whether a hospital is eligible for a DSH payment and, if so, how much based on multiple variables associated with that fiscal year (*e.g.*, the number of Medicaid eligible days in the relevant fiscal year).

applicable cost reporting period during the time period for which there is currently no regulation in place that expressly addresses the treatment of Part C days."[53]

2. "We do not agree that it is arbitrary or capricious to treat hospitals' Part C days differently on the basis of the timing of their appeals vis-a-vis Supreme Court and lower court decisions. The instructions to contractors that issued after the *Northeast* decision cannot control over the holding of the Supreme Court in *Allina II.* It is also not unusual for cost reports to be finalized differently from one another with respect to a legal issue depending on the outcome of litigation raising that issue and the status of a hospital's appeal at the time of a final non-appealable decision. Providers will also be able to request to have their Medicare fraction realigned to be based on their individual cost reporting periods rather than the Federal fiscal year, in accordance with the normal rules. **Providers who remain dissatisfied after receiving NPRs and revised NPRs that reflect the interpretation adopted in this final action retain appeals rights and can challenge the reasonableness of the Secretary's interpretation set forth in this final action**."[54]

3. "Providers who have pending appeals reflecting fractions calculated in the absence of a valid rule will receive NPRs or revised NPRs reflecting DSH fractions calculated pursuant to this new final action and *will have appeal rights with respect to the treatment of Part C days in the calculation of the DSH fractions* ***contained in the NPRs or revised NPRs***. Providers whose appeals of the Part C days issue have been remanded to the Secretary *will likewise receive NPRs or revised NPRs* reflecting fractions calculated pursuant to this new final action, *with attendant appeal rights*. Because NPRs and revised NPRs will reflect the application of a new DSH Part C days rule, CMS will have taken action under the new action, and *the new or revised* ***NPRs*** *will provide hospitals with a* ***vehicle to appeal*** *the new final action* even if the Medicare fraction or DSH payment does not change numerically."[55]

4. "*When the Secretary's treatment of Part C days in this final action is reflected* ***in NPRs and revised NPRs****, providers*, including providers whose appeals were remanded under the [CMS] Ruling [1739-R], *will be able to challenge the agency's interpretation* ***by appealing those NPRs and revised NPRs***. While some providers have already received reopening notices and had their NPRs held open for resolution of the Part C days issue, the issuance of new NPRs and revised NPRs pursuant to remands under the Ruling are not reopenings."[56]

The above discussion in the preamble to the June 2023 Final Rule makes clear that hospitals would be *not* able to ***directly*** appeal from Final Rule since the finalized policy is not applied in the Final Rule to any specific hospitals and the preamble's discussion of a hospital's right to challenge that finalized policy is only in the context of the yet-to-be issued NPRs (original or revised) that: (1) would be issued *following publication of the new SSI percentages*; and (20 would both apply the finalized policy and would be sued to determine DSH eligibility for a hospital's prior pre-October 1, 2013 cost reporting period that is still open for resolution (whether through issuance of

[53] 88 Fed. Reg. at 37774-75 (emphasis added).
[54] *Id.* at 37787 (underline and bold emphasis added and italics emphasis in original).
[55] *Id.* at 37788 (emphasis added).
[56] *Id.* (emphasis added).

an original or revised NPR[57]) and, if so, the amount of the DSH payment. Here, if the June 2023 Final Rule will be applied to them for the fiscal years at issue, then it is clear that Providers' appeals are premature as they will have an opportunity to later file an appeal to challenge the policy at issue once their respective fiscal year NPRs/revised NPRs are issued *consistent with the above excerpts from the preamble to the June 2023 Final Rule and 42 C.F.R. § 412.106(i)*.

The Board recognizes that the Part C issue has a long litigation history and the most recent is referred to as the *Allina II* litigation.[58] However, the *Allina II* litigation has no relevance to the ***jurisdictional*** issue that the Board is addressing in the instant case because that litigation did *not* address the Board's *jurisdiction* over the underlying appeals of the nine (9) Plaintiff hospitals in *Allina II* (*i.e.*, it does not address whether the publication of the SSI ratios was a "final determination" *for purposes of 42 U.S.C. § 1395oo(a)(1)(A)(ii)*).[59]

Similarly, the Board declines to follow D.C. District Court's decision in *Battle Creek*[60] and instead continues to find the D.C. District Court's 2022 decision in *Memorial Hospital* to be instructive.

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[57] Just because a hospital was eligible for a DSH payment in the original NPR, does not mean that the hospital would *continue* to be eligible for a DSH payment following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Similarly, the converse may be true. As such, a hospital eligibility status may change following the issuance of a revised NPR pursuant to the June 9, 2023 Final Rule. Moreover, there could be other DSH variables at play in the NPR/revised NPR such as consideration of Medicaid eligible days (removal or addition of such days) depending on what other issues may remain open in the relevant fiscal year.

[58] *Allina II* began as *Allina Health Servs. v. Burwell*, No. 14-01415, (D.D.C. Aug. 19, 2014) resulting in *Allina Health Servs. v. Burwell*, 201 F. Supp. 3d 94 (D.D.C. 2016), *reversed Allina Health Servs. v. Price*, 863 F.3d 937 (D.C. Cir. 2017), *aff'd sub nom. Azar v. Allina Health Servs.*, 139 S. Ct. 1804 (2019) ("*Allina II*").

[59] Rather, *Allina II* addresses the Board's "no-authority determination" when it granted EJR for the *Alliana II* providers. This is not a *jurisdictional* issue under 42 U.S.C. § 1395oo(a)(1), but rather an issue relating to whether the Board appropriately granted EJR pursuant to 42 U.S.C. § 1395oo(f)(1). Further, the Board takes administrative notice that, in the Complaint filed to establish the *Allina II* litigation, ***none*** of the 9 Plaintiff hospitals based their right to appeal on the publication of the SSI fractions pursuant to 42 U.S.C. § 1395oo***(a)(1)(A)(ii)***. Rather, the Complaint makes clear that each of the 9 Plaintiff hospitals based their right to appeal *on the failure of the Medicare Contractor to timely issue an NPR as set forth in 42 U.S.C. § 1395oo**(a)(1)(B)*** as implemented at 42 C.F.R. § 405.1835(c) (2014). *Allina Health Servs. v. Burwell*, No. 14-01415, Complaint at ¶¶ 38-39 (D.D.C. Aug. 19, 2014) (stating: 38. . . . None of the [9] plaintiff Hospitals has received an NPR reflecting final Medicare DSH payment determinations for their cost reporting periods beginning in federal fiscal years 2012. 39. As a result, *the [9] plaintiff Hospitals timely filed appeals to the Board*, ***pursuant to 42 U.S.C. §§ 1395oo(a)(1)(B)***, to challenge the agency's treatment of Medicare part C days as Medicare part A days for purposes of the part A/SSI fraction and the Medicaid fraction of the Medicare DSH calculation for their 2012 cost years." (footnote omitted and emphasis added)).

[60] The Board recognizes that, in *Battle Creek*, the D.C. District Court addressed a jurisdictional issue involving DSH SSI fractions ***similar to*** the jurisdictional issue that the *same* Court (different judge) issued in *Memorial Hospital* but reached a different conclusion. However, the Board disagrees with the *Battle Creek* decision and maintains that *Memorial Hospital* is a better-reasoned decision and, in particular, provides a more thoughtful analysis and application of the D.C. Circuit's decision in *Washington Hospital*. Indeed, the *Battle Creek* decision does not even discuss the *Memorial Hospital* decision that was issued 19 months earlier by a different judge in the ***same*** Court. Finally, *Battle Creek* is distinguishable from the cases at hand. *Battle Creek* addressed whether the publication of SSI fractions is a final determination. In contrast, (as discussed *infra*) the Providers did *not* appeal the publication of SSI fractions but rather the final rule finalizing the policy at issue ***prior to*** the issuance of new SSI fractions to be used in the yet-to-be issued NPRs/revised NPRs for the hospital covered by the terms of that final rule. To this end, in finalizing that policy in the June 2023 Final Rule, the Secretary announced that "CMS must calculate DSH payments for periods that include discharges occurring before the effective date of the prospective FY 2014 IPPS final rule for hundreds of hospitals whose DSH payments ***for those periods are still open or have not yet been finally settled*** . . . ." 88 Fed. Reg. at 37774 (emphasis added).

Memorial Hospital concerns another variable used in the DSH adjustment calculation. Specifically, the providers in that case appealed ***the publication of their DSH SSI ratios*** (which is one step *after* the cases at hand where Providers are appealing the final rule adopting/finalizing a policy ***prior to*** the publication of the DSH SSI ratios reflecting that Final Rule[61]). The providers in *Memorial Hospital* argued that there are certain instances where a provider can appeal prior to receiving an NPR and gave citations to certain D.C. Circuit cases in support. However, the D.C. District Court distinguished this case because "the secretarial determination at issue was either the only determination on which payment depended or clearly promulgated as a final rule."[62] The D.C. District Court ultimately agreed with the Board that this was not an appealable final determination. In its discussion, the D.C. District Court agreed with the Secretary that the publication of the SSI ratios, *even if the publication of the SSI fractions had been issued as "final,"* it could and would not be a final determination "as to the amount of payment" because the SSI fractions are "just one of the variables that determines whether hospitals receive a DSH payment ***and***, ***if so***, *for how much*."[63] The D.C. District Court concluded:

> A challenge to *an* ***element*** *of payment* under 42 U.S.C. § 1395oo(a)(1)(A)(ii) is ***only*** *appropriate* ***if***, as the D.C. Circuit has explained, "*the Secretary ha[s] firmly established '****the only variable factor*** in the final determination as to the amount of payment under § 1395ww(d).'" *Monmouth Med. Ctr. v. Thompson*, 257 F.3d 807, 811 (D.C. Cir. 2001) (quoting *Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 147 (D.C. Cir. 1986)) (emphasis added); *see also Samaritan Health Serv. v. Sullivan*, 1990 WL 33141 at *3 (9th Cir. 1990) (unpublished table decision) ("We have held that if the Secretary's classification of a hospital effectively fixes the hospital's reimbursement rate, then that decision is a 'final determination' as referred to 42 U.S.C. § 1395oo(a)(1)(A)(ii).").[64]

Accordingly, the Court upheld the Board's decision to dismiss because the DSH SSI fraction was only one of the variables that determine whether a hospital receives a DSH payment (and, if so, for how much) and the publication of a hospital's SSI fraction is not a determination as to the amount of payment received.[65]

This is what makes these cases distinguishable from the facts presented in the D.C. Circuit's decisions in *Washington Hospital* where the determination that was appealed finalized the only hospital-specific variable used in setting the per-patient payment amount. Specifically, the

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[61] The Providers' appeal requests are clear that they were filed to appeal from the June 2023 Final Rule, as opposed to appeal from any publication of SSI fractions. Indeed, it is not clear from the record before the Board whether any new SSI percentages for these Providers *for the specific fiscal years appealed* have been in fact issued *pursuant to the implementation of the June 2023 Final Rule as set forth therein*. To this end, the Board notes that 42 C.F.R. § 405.1837(c)(3) requires an appeal request to include a copy of the final determination being appealed, but none of the appeal request include a copy of the publication of any SSI fractions.

[62] 2022 WL 888190 at *8.

[63] *Id.* at *9 (emphasis added).

[64] *Id.* at *8.

[65] *Id.* at *9.

hospitals in *Washington Hospital* appealed their "Final Notice of Base Period Cost and Target Amount Per Discharge" and the D.C. Circuit found: (a) "the ***only variable*** *factor* in the final determination as to the amount of payment under § 1395ww(d) is the hospital's target amount . . . ";[66] and (b) "The amount is the per-patient amount calculated under § 1395ww(d) and is final once the Secretary has published the DRG amounts (as has) and finally determined the hospital's target amount. Here each of the hospitals has received a 'Final Notice of Base Period Cost and Target Amount per Discharge.' The statute requires no more to trigger the hospital's right to appeal PPS Payments to the PRRB."[67]

Similar to the D.C. District Court's decision in *Memorial Hospital*, while the policy at issue in these cases was finalized in the June 2023 Final Rule, it is ***not*** a "final determination" as to the amount of payment received by Providers for their various fiscal years at issue. Rather, the June 2023 Final Rule reflects "just one of the variables that determines whether hospitals receive a DSH payment [for the relevant fiscal year] ***and***, ***if so***, *for how much*"; and any "***final*** *payment* determination"[68] on whether a hospital receives a DSH payment for a particular fiscal year and, if so, for how much *is made during the cost report audit/settlement process as explained at 42 C.F.R. § 412.106(i)*.[69] In this regard, the Board again notes that the June 2023 Final Rule did not make a determination on any specific hospital's DSH eligibility and, if so, the amount of DSH payment. Rather, as it relates to this appeal, the Final Rule adopts a policy that is to be applied *retroactively* but only to certain hospitals and makes clear that, *following the publication of new SSI percentages*, those affected hospitals who had open cost reporting periods for this issue would be issued an NPR (original or revised) that both would apply the finalized policy and would determine: (a) the hospital's DSH eligibility for relevant period that remains open for resolution (whether for issuance of an original or revised NPR); and (b) if so, the amount of the DSH payment.[70]

In summary, the Board finds that the June 2023 Final Rule appealed in the instant case is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a) and the appeal (as alleged) appears premature.[71] Accordingly, the Board finds it is appropriate dismiss the instant appeal and remove it from the Board's docket, since satisfying the criteria set out in 42 C.F.R. § 405.1835(a) is required (as explained in 42 C.F.R. §§ 405.1837(a)(1) and 405.1837(c)(1)) before the Board can exercise jurisdiction over an appeal,[72] and since the Providers have failed to demonstrate in its hearing request that those criteria have been met for the fiscal years under appeal.[73]

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[66] 795 F.2d at 143 (emphasis added).
[67] *Id.* at 147 (footnote omitted).
[68] 42 C.F.R. § 412.106(i)(2) (emphasis added).
[69] 2022 WL 888190 at *9 (emphasis added).
[70] *See infra* at Section C of the Decision confirming that none of the Providers properly appealed from the alleged publication of SSI fractions "on or about October 15, 2023."
[71] The Board's dismissal does not mean that the Secretary's policy finalized in the June 2023 Final Rule cannot be appealed. As noted *supra* in the preamble to the June 2023 Final Rule, providers may appeal NPRs or revised NPRs that are subsequently issued and reflect this policy *as it relates to prior periods held open for this issue*. This may encompass the Providers depending on the nature and status of the alleged remand(s) referenced by the Providers and the issuance of revised NPRs as appropriate and consistent with the terms of that remand.
[72] 42 C.F.R. § 405.1840(a), (b).
[73] 42 C.F.R. § 405.1837(c).

B. To the extent the Providers are also attempting to appeal from the alleged publications of SSI Ratios "published on or about October 15, 2023," the Board would similarly dismiss these appeals because the appeal requests are <u>fatally</u> flawed.

To the extent the Providers are also attempting to appeal from the *alleged* publications of SSI Ratios published "*on or about October 15, 2023*", the Board would similarly dismiss these appeals because, notwithstanding the requirements in 42 C.F.R. §§ 405.1837(c), the Providers did not properly identify it as a "final determination being appealed nor did they attach a copy of that publication to their appeal request *as specifically required under those regulations*. A vague reference to CMS posting the alleged publication on its website does not and cannot satisfy the specific regulatory requirement to attach a copy of the final determination being appealed to the appeal request.

To this end, a copy of the actual determination being appealed is needed to confirm a number of basic jurisdictional requirements. In this respect, it is not clear whether each of these Providers were, in fact, included in that alleged publication "on or about October 15, 2023" (much less whether *each Provider's relevant fiscal year* is even open/pending for the DSH SSI Part C issue as discussed in Section C below). Similarly, it is unclear from the appeal requests what years are covered by the *alleged* publication and whether that corresponds to the years under appeal. Finally, the Board notes that the Providers are unsure of the date of the *alleged* publication, and that an *actual* publication date is not documented in the record. As a result, it would be impossible for the Board to determine whether an appeal of the *alleged* publication was timely filed.

Based on the above, it is clear that any Provider claims that they appealed from the *alleged* publication of the SSI rations at issue would be fatally flawed and the Board would exercise its discretion under to dismiss those appeals for failure to comply with the mandatory content requirements for appeal requests located at 42 C.F.R. §§ 405.1837(c).

C. Even if the June 9, 2023 Final Rule Could Be Appealed as a "Final Determination" Under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' Appeal Requests Failed to Meet the Minimum Content Requirements For an Appeal Request to Demonstrate that the Final Rule Was, In Fact, Applicable to Them For the Fiscal Years at Issue.

42 C.F.R. § 405.1837(c) specifies the content requirements for a request for a Board hearing as a group appeal. The Providers have not provided any explanation in their appeal requests of why the Board has jurisdiction over their appeal and *none has included **<u>any</u>** information related to any relevant NPRs or revised NPRs or any information on any other pending appeal that may have been remanded to the MAC by Court Order and/or CMS Ruling 1739-R*. In this regard, the Board notes that it is the Providers' responsibility under 42 C.F.R. § 405.1837(c) and Board Rules to include the necessary documentation in the appeal request to demonstrate the Board's jurisdiction over the appeals.

42 C.F.R. § 405.1837(a)(1) makes clear that a provider's right to a Board hearing as part of group appeal is dependent on "[t]he provider satisfy[ng] individually the requirements for a Board

hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement." One of the requirements in § 405.1835(a) is that the provider is appealing "a final contractor or Secretary determination."

The content requirements for a group appeal request are located at 42 C.F.R. § 405.1837(c) and specify that the appeal request must "demonstrate[e] that the request satisfies the requirements for a Board hearing as a group appeal, as specified in paragraph (a) of this section" and that, in addition to the "final contractor or Secretary determination under appeal", must include "any other documentary evidence the providers consider to satisfy the hearing request requirements of paragraphs (c)(1) . . . of this section."

Here, none of the Providers include as part of their appeal requests any documentation relating to which final contractor or Secretary determination they seek to appeal, notwithstanding their responsibilities under 42 C.F.R. § 405.1837(c) as quoted above.

Without having the NPR or any additional documentation on the Providers' final determination as it relates to the fiscal years at issue, the Board cannot confirm that the June 2023 Final Rule is, *in fact*, applicable to the Provider's for the fiscal years at issue (*i.e*., that the fiscal years appealed by the Providers remain open and are eligible for resolution of the Part C days issue raised in the this appeal *through the operation of the June 2023 Final Rule*). The Group Representative only includes the following obtuse statement in the group issue statement without explaining what it means or providing any documentation to establish it as true for each of the participants: "Providers previously, successfully challenged CMS's unlawful change in policy governing the treatment of Part C Days pre-FFY 2014; because the Final Rule was issued as a remedy for CMS's prior unlawful conduct, this challenge is a continuation of Providers' earlier appeals—including any such interest accruing thereunder."

Similarly, if the Providers' had remand(s) for the DSH SSI Part C issue for the fiscal years at issue and those remands were still pending before MAC, then the Remand Order itself (whether from a Court, the Administrator, or the Board) is relevant since it might otherwise preclude Board consideration of these appeals; however, the Providers failed to submit any documentation with the appeal requests to confirm any such remands.[74] In this regard, the Board is unable to determine whether each of the Providers even qualified for a DSH payment during the fiscal years at issue since the record does not include a copy of the relevant NPR/revised NPR with the relevant audit adjustment pages alleged to have been issued to the Providers for the relevant fiscal years. Accordingly, the Board finds that the Providers' group appeal requests are *fatally* flawed because, even if the June 2023 Final Rule were an appealable "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), it is unclear whether that Final Rule is, in fact, applicable *to the fiscal years appealed by the Provider* given their failure to comply with the content requirements of 42 C.F.R. § 405.1837(c) requiring its appeal request demonstrate that each of the Providers satisfies the requirements for Board hearing and that the "final determination" being appealed, *in fact*, involves

[74] *See also* CMS Ruling 1739-R; Board Rule 4.6 (entitled "No Duplicate Filings" and specifying in 4.6.2 that "Appeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal").

a payment determination ***retroactively*** *applicable to them* under the terms of the Final Rule. This finding serves as an alternative and *independent* basis for the Board's dismissal of these appeals.

D. The Providers' Appeal Requests Pertains to Multiple Years, in violation of Board Rules

Consistent with 42 C.F.R. § 405.1837(b), Board Rule 12.5 reads, in part:

> A group may cover ***only one*** *calendar year* ***unless*** *the Board allows the group to be expanded*. Specifically, providers in a group appeal must have final determinations for their cost reporting periods that *end within the same* ***calendar year***. However, a group may submit a written request to include more than one calendar year if it cannot meet the minimum number of provider or the $50,000 amount in controversy requirements.[75]

Here, each of the instant appeals purports to pertain to "CY 2023" given that all the group have "CY 2023" in their title; however, each of the participants lists multiple fiscal years that do not pertain to or relate to "CY 2023," *in violation of Board Rules*.[76] For example, Case No. 24-0219GC involves 2 participants where Participant No. 1 is appealing is fiscal years ending December 31, 2007 and December 31, 2011 and, in contrast, Participant No. 2 is appealing its fiscal years ending December 31, 2006 and December 31, 2010. Thus in this group each participant is appeal 2 years and neither participant is appealing the same year.

Accordingly, the Board finds the Providers failed to comply with the Board's governing regulations and rules limiting group appeals to one year unless approved by the Board in advance. The Group Representative did not obtain approval from the Board prior to filing. ***Accordingly, the Boad admonishes Hall Render for failing to follow these Board Rules and it failure to obtain prior Board approval***. If these appeals had been valid, the Board would consider remedial action (including potentially dismissal, as appropriate) and, at a minimum, would need to consider bifurcation/reorganization of the groups.

E. One Participant Also Can Be Dismissed For Failure to File A Timely Appeal of the June 2023 Final Rule

Hall Render directly added Saint Joseph Mercy Saline Hospital (Prov. No. 23-0212, 6/30/2007) to Case No. 24-0412GC more than 180 days after the publication of the June 2023 Final Rule.

Specifically, Hall Render directly added this participant on December 7, 2023 which is 181 days after the June 2023 Final Rule was published. The Board finds that the direct-add request (*i.e.*, appeal requests) was ***not*** timely filed as required by the Board's enabling statute at 42 U.S.C. § 1395oo(a)(3), which specifies that appeals of Federal Register Notices (*i.e*., appeals under 42 U.S.C. § 1395(a)(1)(ii)) must be filed "*within . . . 180 days after* ***notice*** *of the Secretary's final*

[75] (Emphasis added.)

determination."[77] The direct-add request was filed in OH CDMS ***one day past*** the filing deadline of 180 days after the issuance of the June 2023 Final Rule.

Consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. § 405.1835(a)(3) specifies that a provider's appeal request must be filed no later than 180 days after the "date of receipt" of the final determination being appealed:

> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.

The regulation at 42 C.F.R. § 405.1837(a)(1) makes clear that this requirement applies to provider's participating in a group appeal whether by transfer or direct add.[78] To this end, Board Rule 7.1.1 specifies that the appeal request must "[i]dentify the date the final determination ***was issued***"[79] and Board Rule 4.3.2 specifies in connection with appeals based on a Federal Register Notice that: (1) "[t]he date of receipt of a Federal Register Notice is the date the Federal Register is published"; and (2) "[t]he appeal period begins on the date of publication and ends 180 days from that date."

The Board is bound by all of the provisions of Title XVIII of the Act (the Social Security Act, as amended) and the regulations issued thereunder.[80] The Board cannot apply a regulation or instruction which is contrary to a statute and other regulations that deal specifically with the matter at hand: the date a provider is deemed to have notice of the contents of the Federal Register. In this case, the laws and regulations governing the publication of Federal Register notices specifically define the time of notice as that of publication. These laws and regulations have been incorporated into Title XVIII.

The Secretary[81] has enacted Part 401 of Title 42 of the Code of Federal Regulations which is entitled "General Administrative Requirements." Subpart B, §§ 401.101(a)(1) and (2) of this Part states that "[t]he regulations in this subpart: (1) Implement section 1106(a)[82] of the Social Security Act [relating to disclosure of information] as it applies to [CMS] . . . [and] (2) Relate to the availability to the public, under 5 U.S.C. § 552,[83] of records of CMS." These laws and

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[77] (Emphasis added.)
[78] 42 C.F.R. § 405.1837(a)(1) specifies that a provider's right to participate in a group is dependent, in part, on the "[t]he provider satisfy[ying] 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)." NOTE – none of the providers in these appeals have alleged that they are appealing from the nonissuance of an NPR or revised NPR consistent with § 405.1835(c) and, to that end, there is no information in the records for these cases to support such an allegation consistent with Board Rule 7.5.
[79] (Emphasis added.)
[80] *See* 42 C.F.R. § 405.1867.
[81] of the Department of Health and Human Services.
[82] 42 U.S.C. § 1306(a).
[83] 5 U.S.C. § 550 *et seq.* contains the Administrative Procedures Act; 5 U.S.C. § 552 deals with the availability of government information and is known as the Freedom of Information Act ("FOIA").

regulations set out which records are available and how they may be obtained, and they supplement the regulations of CMS relating to the availability of information. Section 401.106 of this subpart, which deals with publication of materials under 5 U.S.C. § 552, requires publication to serve as notice and identifies the Federal Register as the vehicle to be used to give notice. Section 552(a) states in part that:

> (1) Each agency shall separately state and currently publish in the Federal Register for the guidance of the public-
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> * * * *
>
> (D) substantive rules of general applicability adopted as authorized by law, and statements of general policy or interpretations of general applicability formulated and adopted by the agency; and
> (E) each amendment, revision, or repeal of the foregoing.

In order to comply with the statutes and regulations requiring that public notice be given, the Secretary annually publishes the schedules of the Inpatient Prospective Payment System ("IPPS") rates as well as other IPPS policies in the Federal Register pursuant to the requirements of 42 C.F.R. § 412.8(b)(2). The Secretary may issue other changes as Federal Register Notices outside of this annual ratesetting process as was done here with the issuance of the Part C days policy published in the June 9, 2023 Final Rule. These processes were created to comply with 5 U.S.C. § 552 of the Freedom of Information Act which requires that agencies publish regulations and notices in the Federal Register.[84]

With regard to the Notices published in the Federal Register, 44 U.S.C. § 1507 states in part that:

> A document required. . .to be published in the Federal Register is not valid as against a person who has not had actual knowledge of it until the duplicate originals or certified copies of the document have been filed with the Office of the Federal Register and a copy made available for public inspection as provided by section 1503. . . . *[F]iling of a document, required or authorized to be published [in the Federal Register] by section 1505. . .is sufficient to give notice* of the contents of the document to a person subject to or affected by it.[85]

Reflecting new technology and the ability to transmit information immediately upon publication, the Government Printing Office ("GPO") promulgated 1 C.F.R. § 5.10 which authorizes publication of the Federal Register on the internet at the GPO website.[86] The GPO website containing the Federal Register is updated daily at 6 a.m. Monday through Friday, except holidays.[87] Consequently, a provider is deemed to have notice of the Part C days policy at issue on the date the Federal Register

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[84] *See also* 42 C.F.R. Part 401, Subpart B.
[85] (Emphasis added).
[86] *See also* 44 U.S.C. § 4101 (the Superintendent of Documents is to maintain an electronic director and system of online access to the Federal Register).
[87] *See* https://webportal.fedreg.gov/(S(cnt40yxytbq00qf1ogw40sa1))/view/AboutUs.aspx#:~:text=The%20Federal%20Register%20is%20updated,overview%20of%20the%20regulatory%20process.

was published and made available online. Indeed, the Board notes that Notices are often available for public inspection several days ***prior to*** the official publication date and, here, the June 9, 2023 Final Rule was posted to the public at 4:15 pm on June 7, 2023, 2 days in advance of the June, 9, 2023 publication date.[88]

With respect to statutes and regulations dealing with the Federal Register, the Supreme Court has found that:

> Congress has provided that the appearance of rules and regulations in the Federal Register give legal notice of their contents . . . .
>
> . . . Regulations [are] binding on all who sought to come within the [Act], regardless of actual knowledge of what is in the Regulations or of the hardship resulting from innocent ignorance.[89]

The statutes governing the Board (44 U.S.C. § 1507 as applied through the requirements of 42 C.F.R. § 401.101 and the Administrative Procedures Act ("APA")) are clear on their face: ***the date of publication*** of the Federal Register is the date the Providers are deemed to have notice of the June 9, 2023 Final Rule. The Board is bound by all of the provisions of Title XVIII which includes, by reference, the provisions of the Administrative Procedures Act and the Public Printing and Documents law which require that CMS publish its notices and regulations in the Federal Register. In publishing materials in the Federal Register, CMS must comply with the statutes and regulations governing the Superintendent of Documents and the Governing Printing Office.

Pursuant 42 U.S.C. § 1395oo(a)(3), the Board's enabling statute, providers have 180 days "after *notice* of the Secretary's final determination" to file an appeal. To this end, Board Rule 4.3.2 confirms that the appeal period for a final rule published in the Federal Register appeal ends 180 days from the date of ***publication***, not the effective date that may be listed in a provision:

> The date of receipt of a Federal Register Notice is the date the Federal Register is ***published***. The appeal period begins on the date of publication and ends 180 days from that date.[90]

In this case, the notice of the Secretary's determination is, by law, the date the Federal Register is issued by the Superintendent of Documents, or June 9, 2023. Here, the 180th day for appealing was ***Wednesday, December 6, 2023***. The direct add request for Saint Joseph Mercy Saline Hospital (Prov. No. 23-0212, 6/30/2007) to Case No. 24-0412GC, was not filed with the Board until ***one day after this deadline*** (specifically December 7, 2023) and, thus, was not timely filed.[91]

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[88] https://www.federalregister.gov/public-inspection/2023/06/07 (last accessed Jan. 19, 2024).
[89] *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 385 (1947).
[90] Emphasis added.
[91] The Providers in these 149 appeals have not requested good cause exception under 42 C.F.R. § 405.1836 and have not presented any evidence suggesting that they would qualify under the criteria specified in that regulation.

Based on the above findings, the Board concludes that the direct-add request of Saint Joseph Mercy Saline Hospital (Prov. No. 23-0212, 6/30/2007) to be added to Case No. 24-0412GC failed to meet the claims-filing requirements for a Board hearing request[92] due to the failure of the Provider to *timely* file its direct-add request to the group to appeal the June 9, 2023 Final Rule by the Wednesday, December 6, 2023 filing deadline consistent with 42 U.S.C. § 1395oo(a)(3), 42 C.F.R. §§ 405.1835(a)(3) and 405.1837(a)(1) and Board Rules 4.3.2 and 7.1.1 and, as such, the Board hereby dismisses it. This is a separate and independent basis to dismiss this participant.

Conclusion:

The Board finds that: (1) the Part C policy issued in the June 2023 Final Rule that the Providers appealed for the fiscal years at issue is not an appealable "final determination" within the context of 42 U.S.C. § 1395oo(a)(1)(A)(ii) and 42 C.F.R. § 405.1835(a); (2) the Providers did not properly appeal the *alleged* publication of the SSI fractions for unspecified years on or about October 15, 2023; and (3) even if the June 2023 Final Rule could be appealable as a "final determination" under 42 U.S.C. § 1395oo(a)(1)(A)(ii), the Providers' appeal request failed to meet the content requirements under 42 C.F.R. § 405.1837(c) based on its failure to demonstrate that the June 2023 Final Rule was, in fact, a payment determination *retroactively* applicable to them for the fiscal years at issue consistent with the terms of that Final Rule. Based on the foregoing, the Board hereby dismisses the 32 group appeals listed in **Appendix A** in their entirety and removes them from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/25/2024

X Clayton J. Nix

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

Enclosure: **Appendix A** – 32 CIRP and Optional Groups

[92] *See* 42 C.F.R. § 405.1840(a), (b). The Board notes that 42 C.F.R. § 405.1840 is entitled "Board Jurisdiction" but it also addresses certain claims-filing requirements such as timelines or filing deadlines. Whether an appeal request is timely filed with the Board is not a jurisdictional requirement per se, but rather it is a claims-filing requirement as the Supreme Court made clear in *Sebelius v. Auburn Reg. Med. Ctr.*, 568 U.S. 145 (2013) ("*Auburn*"). Unfortunately, following the issuance of *Auburn*, the Secretary has not yet updated § 405.1840 to reflect the clarification made by the Supreme Court in *Auburn* that distinguishes between the claims-filing requirements for a Board hearing request versus jurisdictional requirements for a Board hearing. *See also* Board Rule 4.1 ("The Board will dismiss appeals that fail *to meet the timely filing requirements* ***and/or*** *jurisdictional requirements*."); 42 C.F.R. § 405.1835(b) (addressing certain other claims-filing requirements).

cc: Byron Lamprecht, WPS Government Health Administrators (J-8, J-5)
Danelle Decker, National Government Services, Inc. (J-K)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Judith Cummings, CGS Administrators (J-15)
Cecile Huggins, Palmetto GBA (J-J)
Michael Redmond, Novitas Solutions, Inc. (J-H)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Jacqueline Vaughn, OAA
Wilson Leong, FSS

APPENDIX A
Listing of 32 CIRP and Optional Groups

CASE NO.	CASE NAME
24-0219GC	Beacon Health FFY 2023 Part C Days Final Rule CIRP Group
24-0220GC	Medisys Health CY 2023 Part C Days Final Rule CIRP Group
24-0221GC	Advocate Health CY 2023 Part C Days Final Rule CIRP Group
24-0236GC	Truman Med Ctr CY 2023 Part C Days Final Rule CIRP Group
24-0239GC	IU Health CY 2023 Part C Days Final Rule CIRP Group
24-0240GC	Care New England CY 2023 Part C Days Final Rule CIRP Group
24-0245GC	Premier Health Partners CY 2023 Part C Days Final Rule CIRP Group
24-0246GC	NorthShore EdwardElmhurst CY 2023 Part C Days Final Rule CIRP Group
24-0262GC	Community Health Network CY 2023 Part C Days Final Rule CIRP Group
24-0263GC	Franciscan Alliance CY 2023 Part C Days Final Rule CIRP Group
24-0274GC	ProMedica Health CY 2023 Part C Days Final Rule CIRP Group
24-0287GC	ScionHealth CY 2023 Part C Days Final Rule CIRP Group
24-0290GC	Cook County Health CY 2023 Part C Days Final Rule CIRP Group
24-0291GC	Mayo Clinic CY 2023 Part C Days Final Rule CIRP Group
24-0292GC	McLaren Health CY 2023 Part C Days Final Rule CIRP Group
24-0318GC	Good Shepherd Health CY 2023 Part C Days Final Rule CIRP Group
24-0319GC	Froedtert Health CY 2023 Part C Days Final Rule CIRP Group
24-0320GC	Corewell Health CY 2023 Part C Days Final Rule CIRP Group
24-0321GC	Community Healthcare CY 2023 Part C Days Final Rule CIRP Group
24-0322G	Hall Render CY 2023 Part C Days Final Rule Group
24-0323GC	Valley Health CY 2023 Part C Days Final Rule CIRP Group
24-0324GC	WakeMed Health CY 2023 Part C Days Final Rule CIRP Group
24-0325G	Hall Render CY 2023 Part C Days Final Rule Group
24-0326G	Hall Render CY 2023 Part C Days Final Rule Group
24-0327G	Hall Render CY 2023 Part C Days Final Rule Group
24-0328GC	Palmetto Health CY 2023 Part C Days Final Rule CIRP Group
24-0339GC	Ascension Health CY 2023 Part C Days Final Rule CIRP Group
24-0352GC	Parkview Health CY 2023 Part C Days Final Rule CIRP Group
24-0353GC	Norton Healthcare CY 2023 Part C Days Final Rule CIRP Group
24-0355GC	LifePoint Health CY 2023 Part C Days Final Rule CIRP Group
24-0394GC	WVU Medicine CY 2023 Part C Days Final Rule CIRP Group
24-0412GC	Trinity Health CY 2023 Part C Days Final Rule CIRP Group

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Geoff Pike
First Coast Service Options, Inc.
Provider Audit and Reimbursement Dept.
532 Riverside Avenue
Jacksonville, FL 32202

RE: ***Board Decision***
Munroe Regional Medical Center (Prov. No. 10-0062)
FYE: 09/30/2014
Case No.: 19-0138

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 19-0138***

On April 12, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2014.

On October 11, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]

[1] On May 23, 2019, this issue was transferred to PRRB Case No. 18-0109GC.
[2] On May 23, 2019, this issue was transferred to PRRB Case No. 16-1295GC.
[3] On May 23, 2019, this issue was transferred to PRRB Case No. 18-0110GC.
[4] This issue was withdrawn on February 5, 2024.
[5] On May 23, 2019, this issue was transferred to PRRB Case No. 16-1279GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. UCC Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 6, 7, and 9 to Community Health groups on May 23, 2019. After the withdrawal of Issue 5, the remaining issues in this appeal are Issues 1 and 8. On May 31, 2019, the Provider submitted its preliminary position paper.

On August 29, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 8.[8]

On September 13, 2019, the Medicare Contractor filed its preliminary position paper and on September 23, 2019 filed its jurisdictional response.

A Notice of Hearing was issued July 24, 2023, and subsequently the Provider filed its Final Position paper on December 27, 2023 and the Medicare Contractor filed its Final Position Paper on January 30 2024.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0109GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[9]

[6] On May 23, 2019, this issue was transferred to PRRB Case No. 18-0111GC.
[7] On May 23, 2019, this issue was transferred to PRRB Case No. 18-0112GC.
[8] On Jan. 22, 2024, the MAC filed a Jurisdictional Challenge requesting for the dismissal of Issue 5. Issue 5 was subsequently withdrawn by the Provider.
[9] Issue Statement at 1 (Oct. 11, 2018).

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-0109GC, QRS CHS 2014 DSH SSI Percentage CIRP Group, on May 23, 2019. The Group Issue Statement in Case No. 18-0109GC reads:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi)?
>
> **Statement of the Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi). The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] and used by the Lead MAC to settle their Cost Report were incorrectly computed.
>
> The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payor and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.
>
> Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:

1. Availability of MEDPAR and SSA records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calcuation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days[10]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $74,000.

On May 31, 2019, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Florida and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Florida and has learned that similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction.[11]

[10] Group Issue Statement, Case No. 18-0109GC.
[11] Provider's Preliminary Position Paper at 8-9 (May 31, 2019).

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the SSI realignment portion of the issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of the reimbursement impact.
>
> . . .
>
> The Provider's appeal of this item is premature. The Provider has not formally requested to have its SSI percentage realigned in accordance with 42 C.F.R § 412.106(b)(3). The Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve this issue.[12]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[13]

Issue 8 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[14]

Provider's Jurisdictional Response

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[15] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing

[12] Jurisdictional Challenge at 6-7 (Aug. 29, 2019).
[13] *Id*. at 5-6.
[14] *Id*. at 8.
[15] Jurisdictional Response at 1 (Sept. 23, 2019).

the various errors of omission and commission that do not fit into the "systemic errors" category."[16]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2014 resulting from its understated SSI percentage due to errors of omission and commission."[17]

Issue 8 – UCC Distribution Pool

In response, the Provider argues:

> [R]eview by this Board of the uninsured patient percentage is not barred by 42 U.S.C. §1395ww(r)(3), because such percentages may not be computed on estimates. Moreover, the provisions of 42 U.S.C. § 1395ww(r)(3) reflect intent by Congress to put administrative review on the same footing as judicial review. The ban on judicial review does not apply in connection with mandamus type claims, challenges to regulations, and constitutional challenges. Accordingly, this Board also has jurisdiction over this appeal.[18]

Analysis and Recommendation

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

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board should dismiss both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is

[16] *Id*. at 2.
[17] *Id*.
[18] *Id*. at 7.

duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 18-0109GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[19] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[20] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'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."[21]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 18-0109GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0109GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[22], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 18-0109GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[23] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0109GC.

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0109GC, but instead refers to systemic *Baystate* data matching

[19] Issue Statement at 1.
[20] *Id.*
[21] *Id.*
[22] PRRB Rules v. 2.0 (Aug. 2018).
[23] 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).

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

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[24]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH.[25]
> This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new***

[24] (Emphasis added).
[25] Last accessed February 24, 2023.

> ***self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[26]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0109GC are the same issue.[27] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[28]

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[26] Emphasis added.
[27] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[28] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential

(B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[29] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[30] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[31] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[32]

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[33]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[34] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the

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to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[29] 830 F.3d 515 (D.C. Cir. 2016).
[30] 89 F. Supp. 3d 121 (D.D.C. 2015).
[31] 830 F.3d 515, 517.
[32] *Id.* at 519.
[33] *Id.* at 521-22.
[34] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").

Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[35] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[36]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[37] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[38] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[39] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[40] Nevertheless, the Secretary used each hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[41]

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

[35] *Id.* at 506.
[36] *Id.* at 507.
[37] 514 F. Supp. 249 (D.D.C. 2021).
[38] *Id.* at 255-56.
[39] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[40] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.
[41] *Id.*

another was also a challenge to a "period selected by the Secretary," which is also barred from review.[42]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[43] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[44] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[45]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[46] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[47] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[48] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing

[42] *Id.* at 262-64.
[43] *Id.* at 265.
[44] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).
[45] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).
[46] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).
[47] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[48] *Id.* at *4.

"categorical distinction between inputs and outputs."[49] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Servs*.[50] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[51]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2014 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2014. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Further, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-0109GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Finally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no issues remain pending, the Board hereby closes Case No. 19-0138 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/26/2024

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: PIV

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

[49] *Id.* at *9.
[50] 139 S. Ct. 1804 (2019).
[51] *Ascension* at *8 (bold italics emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Decision*** **– DSH Payment/SSI Percentage (Provider Specific)**
South Baldwin Regional Medical Center (Provider Number 01-0083)
FYE: 09/30/2015
Case Number: 19-0452

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 19-0452***

On May 21, 2018, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end September 30, 2015.

On November 16, 2018, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained five (5) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days[2]
4. Uncompensated Care ("UCC") Distribution Pool[3]
5. 2 Midnight Census IPPS Payment Reduction[4]

As the Provider is owned by Community Health Systems, Inc. ("Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 4 and 5 to Community Health CIRP groups on June 13, 2019. After the withdrawal of Issue 3, the sole remaining issue in this appeal is Issue 1.

[1] On June 13, 2019, this issue was transferred to PRRB Case No. 18-0552GC.
[2] This issue was withdrawn on March 8, 2024.
[3] On June 13, 2019, this issue was transferred to PRRB Case No. 18-0555GC.
[4] On June 13, 2019, this issue was transferred to PRRB Case No. 18-0554GC.

On January 5, 2024, the Provider filed its final position paper.

On January 17, 2024, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issue 1.[5]

On February 5, 2024, the Medicare Contractor filed its final position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 18-0552GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[6]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 18-0552GC, QRS CHS 2015 DSH SSI Percentage CIRP Group, on June 13, 2019. The Group Issue Statement in Case No. 18-0552GC reads:

> **Statement of the Issue:**
>
> Whether the Medicare/SSI fraction used in the Medicare Disproportionate Share Hospital and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?

[5] The Jurisdictional Challenge also challenged jurisdiction over Issue 3, which was subsequently withdrawn.
[6] Issue Statement at 1 (Nov. 16, 2018).

Statement of the Legal Basis

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

The Provider(s) also contend(s) that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires SSI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.

The Provider(s) further contend(s) that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael O. Leavitt*, 545 F.Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute.

Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not used in the Baystate case:

1. Availability of MEDPAR and SSA records
2. Failure to adhere to required notice and comment rulemaking procedures
3. Fundamental problems in the SSI percentage calculation
4. Not in agreement with provider's records
5. Paid days vs. Eligible days, and
6. Covered days vs. Total days[7]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $29,000.

[7] Group Issue Statement, Case No. 18-0552GC.

On January 5, 2024, the Provider filed its final position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

> **Provider Specific**
>
> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> The Provider is seeking a *full and complete* set of the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. *See* 65 Fed. Reg. 50,548 (2000). Although some MEDPAR data is now routinely made available to the provider community, what is provided lacks all data records necessary to fully identify all patients properly includable in the SSI fraction. The Provider believes that upon completion of this review it will be entitled to a correction of these errors of omission to its' SSI percentage based on CMS's admission in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) that errors occurred that did not account for all patient days in the Medicare fraction. The hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3).[8]

MAC's Contentions

The MAC argues that the Board lacks jurisdiction over the DSH Payment/SSI Percentage (Provider Specific) issue for three reasons. First, the MAC argues that the SSI realignment portion of the issue has been abandoned by the Provider:

> The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper PRRB Rule 25.3 addresses issues that are not briefed in a provider's position paper. In relevant part, this rule states:
>
> > Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.[9]

[8] Provider's Final Position Paper at 7-8 (Jan. 5, 2024).
[9] Jurisdictional Challenge at 6-7 (Jan. 17, 2024).

Failing that, the MAC argues the realignment sub-issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final contractor determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> The Provider's appeal is premature. To date 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. The MAC requests that the Board dismiss this issue consistent with recent jurisdictional decisions.[10]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are considered the same issue by the Board.[11]

Finally, the MAC argues "the Provider did not file a **complete** preliminary and final position paper in accordance with 42 C.F.R. § 405.1853 and Board Rules 25.2 and 25.3."[12] The MAC posits that the Provider "failed to sufficiently develop and set forth the relevant facts and arguments regarding the merits of its claim in its Preliminary Position Paper."[13] In more detail, the MAC states:

> Within its Provider's Final Position Paper, the Provider makes the broad allegation that:
>
> > its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation.
>
> . . .
>
> Yet, the Provider offers no evidence or analysis to demonstrate that CMS calculated its SSI percentage inaccurately. The Provider failed to include any evidence to establish the material facts in this

[10] *Id*. at 7.
[11] *Id*. at 4-6.
[12] *Id*. at 8.
[13] *Id*. at 9.

> case relating to inaccuracies in the SSI Percentage calculation at issue without including any evidence to establish the material facts.
>
> Instead, the Provider argues in its final position paper that it lacked sufficient MEDPAR data which, upon receipt of such data, will reveal errors of omission to its SSI percentage; therefore, the Provider is incorporating all arguments presented before the United States Court of Appeals for the District of Columbia in the case of *Advocate Christ Medical Cetner, et al, v Xavier Becerra*. The document was added under Exhibit P-3 of its preliminary paper. The arguments presented in this document did not address the data match issue (a technical issue).[14]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[15] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Analysis and Recommendation

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

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board should dismiss both aspects of Issue 1.

1. First Aspect of Issue 1

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was appealed in PRRB Case No. 18-0552GC.

[14] *Id*. at 9-10.
[15] Board Rule 44.3, v. 2.0 (Aug. 2018).

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "[w]hether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[16] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[17] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'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."[18]

The Provider's DSH/SSI (Systemic Errors) issue in group Case No. 18-0552GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage and the DSH SSI Percentage is improper due to a number of factors. Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 18-0552GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[19], the Board dismisses this aspect of the DSH Payment/SSI Percentage (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 pursuing that issue as part of the group under Case No. 18-0552GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[20] The Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0552GC.

To this end, the Board also reviewed the Provider's Final Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 18-0552GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 (as applied via Board

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[16] Issue Statement at 1.
[17] *Id.*
[18] *Id.*
[19] PRRB Rules v. 2.0
[20] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

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

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable,* identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[21]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such as MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

> https://www.cms.gov/Research-Statistics-Data-and-Systems/Files-for-Order/Data-Disclosures-Data-Agreements/DUA_-_DSH. [22]

[21] (Emphasis added).
[22] Last accessed March 26, 2024.

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[23]

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 18-0552GC are the same issue.[24] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

Additionally, in its Final Position Paper, the Provider stated, "The [Provider] hereby incorporates all of the arguments presented before the United States Court of Appeals for the District of Columbia in the case of Advocate Christ Medical Center, et al, v Xavier Becerra (Appellants' reply brief included as Exhibit P-3)."[25] The Board finds that this purported argument does not comply with the regulations and Board rules to *fully* develop the Provider's position in the Final Position Paper, because the Provider merely lists a case name and does not explain further what the arguments are that it would like to incorporate into its appeal.

42 C.F.R. § 405.1853 addresses position papers and specifies in pertinent part:

> (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*.[26]

Therefore, the Board finds that the Provider did not comply with the Final Position Paper regulations and Board rules with respect to the purported *Advocate Christ* argument and dismisses that portion of the issue.

2. Second Aspect of Issue 1

The Board finds the second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue was abandoned by the Provider. Board Rule 25.3 reads, in pertinent part:

> Any issue appealed, but not briefed by the Provider in its position paper will be considered withdrawn.

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[23] Emphasis added.
[24] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).
[25] Provider's Final Position Paper at 7-8.
[26] (Emphasis added).

The Board finds that the realignment portion of the DSH Payment/SSI Percentage issue was not briefed in the final position paper and is therefore, abandoned.

The Board also notes that the realignment portion of the appealed issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—would have been dismissed by the Board even if it was briefed, as the issue is premature.

The Board notes that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination with which the Provider can be dissatisfied for appeal purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board should note that it lacks jurisdiction in this aspect of the appeal. Further, the Board notes that the Provider's cost reporting period ends on 9/30, which is congruent with the Federal fiscal year, and as such, realignment of the SSI percentage would have no effect on reimbursement.

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In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 18-0552GC and the realignment portion was not briefed in the Final Position Paper and is therefore abandoned. As no issues remain pending, the Board hereby closes Case No. 19-0452 and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

3/26/2024

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***Board Decision***
Steward Melbourne Hospital (Prov. No. 10-0291)
FYE: 04/30/2017
Case No.: 19-2656

Dear Mr. Ravindran and Mr. Pike,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

A. ***Procedural History for Case No. 19-2656***

On March 15, 2019, the Provider was issued a Notice of Program Reimbursement ("NPR") for fiscal year end April 30, 2017.

On September 11, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained nine (9) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[3]
5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]

[1] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1332GC.
[2] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1333GC.
[3] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1334GC.
[4] This issue was withdrawn on March 1, 2024.
[5] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1335GC.

7. DSH Payment – Medicaid Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]
8. UCC Distribution Pool
9. 2 Midnight Census IPPS Payment Reduction[7]

As the Provider is owned by Community Health Systems, Inc. (hereinafter "Community Health") and, thereby, subject to the mandatory CIRP group regulation at 42 C.F.R. § 405.1837(b)(1), the Provider transferred Issues 2, 3, 4, 6, 7, and 9 to Community Health groups on April 21, 2020. After the withdrawal of Issue 5, the remaining issues in this appeal are Issues 1 and 8. On May 4, 2020, the Provider submitted its preliminary position paper.

On July 23, 2020, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of Issues 1 and 8.[8]

On August 19, 2020, the Medicare Contractor filed its preliminary position paper.

B. Description of Issue 1 in the Appeal Request and the Provider's Participation in Case No. 20-1332GC

In their Individual Appeal Request, Provider summarizes its DSH Payment/SSI Percentage (Provider Specific) issue as follows:

> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> 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.[9]

As the Provider is commonly owned by Community Health, the Provider transferred its Issue 2 – DSH/SSI Percentage to the CIRP group under 20-1332GC, CHS CY 2017 HMA DSH SSI Percentage CIRP Group, on April 21, 2020. The Group Issue Statement in Case No. 20-1332GC reads:

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[6] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1336GC.
[7] On April 21, 2020, this issue was transferred to PRRB Case No. 20-1337GC.
[8] On Jan. 30, 2024, the MAC filed a Jurisdictional Challenge requesting for the dismissal of Issue 5. Issue 5 was subsequently withdrawn by the Provider.
[9] Issue Statement at 1 (Sept. 11, 2019).

Statement of the Issue:

Whether the Secretary properly calculated the Provider's Disproportionate Share Hospital ("DSH")/Supplemental Security Income ("SSI") percentage, and whether CMS should be required to recalculate the SSI percentages using a denominator based solely upon covered and paid for Medicare Part A days, or alternatively, expand the numerator of the SSI percentage to include paid/covered/entitled as well as unpaid/non-covered/eligible SSI days?

Statement of the Legal Basis

The Provider(s) contend(s) that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § 1395ww(d)(5)(F)(vi)(I). The Provider(s) further contend(s) 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,
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.[10]

The amount in controversy listed for both Issues 1 and 2 in the Provider's individual appeal request is $13,000.

On May 4, 2020, the Provider filed its preliminary position paper. The following is the Provider's ***complete*** position on Issue 1 set forth therein:

Provider Specific

The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include

[10] Group Issue Statement, Case No. 20-1332GC.

> all patients that were entitled to SSI benefits in their calculation based on the Provider's Fiscal Year End (April 30).
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> Similar to *Loma Linda Community Hospital v. Dept of Health and Human Services*, No. CV-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records. However, at this time, the Provider has been unable to analyze the Medicare Part A data because it has not yet received the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR"), HHS/HCFA/OIS, 09-07-009, which was published in the Federal Register on August 18, 2000 from CMS. *See* 65 Fed. Reg. 50,548 (2000). Upon release of the complete MEDPAR data, the Provider will seek to reconcile its' records with that of CMS, and identify patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS based on the Federal Fiscal Year End (September 30) when it determined the Provider's SSI. *See Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).[11]

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

First, the MAC argues that the Provider has abandoned the SSI realignment sub-issue: "The MAC contends that the Provider has abandoned the issue of SSI realignment and, therefore, it should be considered withdrawn. The Provider did not brief this issue within its preliminary position paper."[12] Failing that, the MAC argues the SSI realignment issue is premature:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a Provider election. It is not a final MAC determination. A Provider must make a formal request to the MAC and CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .

[11] Provider's Preliminary Position Paper at 8-9 (May 4, 2020).
[12] Jurisdictional Challenge at 5 (Jul. 23, 2020).

> To date 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. The MAC requests that the Board dismiss this issue consistent with the recent jurisdictional decisions previously cited.[13]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH/SSI Percentage (Systemic Errors) issue in PRRB Case No. 20-1332GC are considered the same issue by the Board.[14]

Issue 8 – UCC Distribution Pool

The MAC argues "that the Board does not have jurisdiction over the UCC DSH payment issue because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2)."[15]

Provider's Jurisdictional Response

The Board Rules require that Provider Responses to the MAC's Jurisdictional Response must be filed within thirty (30) days of the filing of the Jurisdictional Challenge.[16] The Provider has not filed a response to the Jurisdictional Challenge and the time for doing so has elapsed. Board Rule 44.4.3 specifies: "Providers must file a response within 30 days of the Medicare contractor's jurisdictional challenge. Failure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to 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.

A. DSH Payment/SSI Percentage (Provider Specific)

The jurisdictional analysis for Issue 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period. As set forth below, the Board dismisses both aspects of Issue 1.

1. First Aspect of Issue 1

[13] *Id*. at 5-6.
[14] *Id*. at 3-4.
[15] *Id*. at 8.
[16] Board Rule 44.4.3, v. 2 (Aug. 2018).

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI Percentage (Systemic Errors) issue that was appealed in PRRB Case No. 20-1332GC.

The DSH Payment/SSI Percentage (Provider Specific) issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[17] The Provider's legal basis for its DSH Payment/SSI Percentage (Provider Specific) issue asserts 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)."[18] The Provider argues that "its' SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . disagrees with the [Medicare Contractor]'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."[19]

The Provider's DSH/SSI Percentage (Systemic Errors) issue in group Case No. 20-1332GC also alleges that the Medicare Contractor and CMS improperly determined 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). Thus, the Board finds the DSH Payment/SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH/SSI Percentage (Systemic Errors) issue in Case No. 20-1332GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.6[20], the Board dismisses this aspect of the DSH Payment/SSI Percentage (Provider Specific) issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case No. 20-1332GC, which is required since it is subject to the CIRP group regulations under 42 C.F.R. § 405.1837(b)(1). 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.[21] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1332GC.

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[17] Issue Statement at 1.
[18] *Id.*
[19] *Id.*
[20] PRRB Rules v. 2.0 (Aug. 2018).
[21] The types of systemic errors documented in *Baystate* did not uniformly impact the SSI calculation for all providers but that does not make the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).

To this end, the Board also reviewed the Provider's Preliminary Position Paper to see if it further clarified Issue 1. However, it did not provide any basis upon which to distinguish Issue 1 from the SSI issue in Case No. 20-1332GC, but instead refers to systemic *Baystate* data matching issues that are the subject of the issue in the group appeal. Moreover, the Board finds that the Provider's Preliminary Position Paper failed to comply with the Board Rule 25 (as applied via Board Rule 27.2) governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions." Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 of its issue and explain the nature of the any alleged "errors" in its Preliminary Position Paper and include *all* exhibits.

Moreover, the Provider has failed to comply with Board Rule 25.2.2 to explain why the MEDPAR data is unavailable. In this regard, Board Rule 25.2.2 specifies:

> **25.2.2 Unavailable and Omitted Documents**
>
> *If documents necessary to support your position are still unavailable*, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.[22]

The Board further notes that the Provider only cites to the 2000 Federal Register but additional issuances and developments on the availability of data underlying the SSI fraction, such MEDPAR data, have occurred. For example, as noted in the FY 2006 IPPS Final Rule, "[b]eginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year." Further highlighting the perfunctory nature of the briefing is the fact that providers *can* obtain certain data used to calculate their DSH SSI ratios directly from the Centers for Medicare and Medicaid Services ("CMS") and in some cases on a self-service basis as explained on the following webpage:

[22] (Emphasis added).

https://www.cms.gov/data-research/files-for-order/data-disclosures-and-data-use-agreements-duas/disproportionate-share-data-dsh.[23]

This CMS webpage describes access to DSH data ***from 1998 to 2017*** as follows: "DSH is now a self-service application. This ***new self-service process*** enables you to enter your data request(s) and retrieve your data files through the CMS Portal."[24]

Indeed, the D.C. Circuit affirmed in *Advocate Christ Med. Ctr. v. Becerra*, No. 22-5214, 2023WL5654312 (D.C. Cir., Sept. 1, 2023) that "What [MMA] section 951 cannot mean is that HHS must give hospitals data that it never received from SSA in the first place. And SSA does not provide HHS with the specific codes assigned to individual patients. See 75 Fed. Reg. at 50,276." Here, the Provider does not explain what information it needs or is waiting on or claims that it should have access to.

Accordingly, the Board finds that the remaining issue in the instant appeal and the group issue from Group Case 20-1332GC are the same issue.[25] Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.6, the Board dismisses this component of the DSH Payment/SSI Percentage (Provider Specific) issue.

2. Second Aspect of Issue 1

The second aspect of the DSH Payment/SSI Percentage (Provider Specific) issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, 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 . . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal.

B. UCC Distribution Pool

The Board finds that it does not have jurisdiction over the DSH UCC payment issue in the above-referenced appeal because jurisdiction is precluded by 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2).

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[23] Last accessed March 26, 2024.
[24] (Emphasis added.)
[25] Moreover, even if it were not a prohibited duplicate, it was not properly in the individual appeal because it is a common issue that would be required to be in a Community Health CIRP group per 42 C.F.R. § 405.1837(b)(1).

1. Bar on Administrative Review

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

> (A) Any estimate of the Secretary for purposes of determining the factors described in paragraph (2).[26]
>
> (B) Any period selected by the Secretary for such purposes.

2. Interpretation of Bar on Administrative Review

a. Tampa General v. Sec'y of HHS

In *Florida Health Sciences Ctr., Inc. dba Tampa Gen. Hosp. v. Sec'y of Health & Human Servs*. ("*Tampa General*"),[27] the U.S. Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") upheld the D.C. District Court's decision[28] that there is no judicial or administrative review of uncompensated care DSH payments. In that case, the provider challenged the calculation of the amount it would receive for uncompensated care for fiscal year 2014. The provider claimed that the Secretary used inappropriate data when she selected the hospital cost data updated in March 2013, instead of data updated in August 2013, when calculating its uncompensated care payments. The provider argued that it was not challenging the estimate of its uncompensated care, but rather the underlying data on which the Secretary relied, judicial review of which is not barred.

The D.C. Circuit found that there was specific language in the statute that precluded administrative or judicial review of the provider's claims because in challenging the use of the March 2013 update data, the hospital was seeking review of an "estimate" used by the Secretary to determine the factors used to calculate additional payments. The D.C. Circuit went on to hold that "the bar on judicial review of the Secretary's estimates precludes review of the underlying data as well."[29] The D.C Circuit also rejected the provider's argument that it could challenge the underlying data, finding that there cannot be judicial review of the underlying data because they are "indispensable" and "integral" to, and "inextricably intertwined" with, the Secretary's estimate of uncompensated care.[30]

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[26] Paragraph (2) is a reference to the three factors that make up the uncompensated care payment: (1) 75 percent of estimated DSH payments that would be paid in absence of § 1395ww(r); (2) 1 minus the percentage of individuals under age 65 who are uninsured in 2013 for the FY 2014 calculation; and (3) the hospital specific value that expresses the proportion of the estimated uncompensated care amount for each subsection (d) hospital with potential to receive DSH payments, to the amount of uncompensated care for all subsection (d) hospitals that receive payment under 42 U.S.C. § 1395ww(r)(2)(C). 78 Fed. Reg. 50496, 50627, 50631 and 50634.
[27] 830 F.3d 515 (D.C. Cir. 2016).
[28] 89 F. Supp. 3d 121 (D.D.C. 2015).
[29] 830 F.3d 515, 517.
[30] *Id*. at 519.

The D.C. Circuit went on to address the provider's attempt to reframe its challenge to something other than an estimate of the Secretary. Specifically, it rejected the characterization as a challenge to the "general rules leading to the estimate rather than as a challenge to the estimate itself []" because it was merely an attempt to undo a shielded determination.[31]

b. DCH Regional Med. Ctr. v. Azar

The D.C. Circuit Court revisited the judicial and administrative bar on review of uncompensated care DSH payments again in *DCH Regional Med. Ctr. v. Azar* ("*DCH v. Azar*").[32] In *DCH v. Azar*, the provider alleged that it was challenging the methodology adopted and employed by the Secretary to calculate Factor 3 of the DSH payment. Indeed, they stated that the bar on review applied only to the estimates themselves, and not the methodology used to make the estimates. The D.C. Circuit disagreed, stating that "a challenge to the methodology for estimating uncompensated care is unavoidably a challenge to the estimates themselves" and that there is "no way to review the Secretary's method of estimation without reviewing the estimate itself."[33] It continued that allowing an attack on the methodology "would eviscerate the statutory bar, for almost any challenge to an estimate could be recast as a challenge to its underlying methodology." Recalling that it had held in *Tampa General* that the choice of data used to estimate an uncompensated care DSH payment was not reviewable because the data is "inextricably intertwined" with the estimates themselves, the D.C. Circuit found the same relationship existed with regard to the methodology used to generate the estimates.[34]

c. Scranton Quincy Hosp. Co. v. Azar

Recently, in *Scranton Quincy Hosp. Co. v. Azar* ("*Scranton*"),[35] the D.C. District Court considered a similar challenge and held that administrative review was precluded. In *Scranton*, the providers were challenging how the Secretary determined the amount of uncompensated care that would be used in calculating Factor 3 for their FY 2015 DSH adjustments.[36] For 2015 payments, the Secretary announced she would calculate DSH payments based on Medicaid and SSI patient days from 2012 cost reports, unless that cost report was unavailable or was for a period less than twelve months. In that scenario, the Secretary would calculate the FY 2015 DSH payments based on either the 2012 or 2011 cost report that was closest to a full twelve month cost report.[37] Since the providers in *Scranton* changed ownership in FY 2012, each had two cost reports that began in 2012: an initial cost report less than twelve months and a subsequent cost report that was a full twelve months.[38] Nevertheless, the Secretary used each

[31] *Id.* at 521-22.
[32] 925 F.3d 503 (D.C. Cir. 2019) ("*DCH v. Azar*").
[33] *Id.* at 506.
[34] *Id.* at 507.
[35] 514 F. Supp. 249 (D.D.C. 2021).
[36] *Id.* at 255-56.
[37] *Id.* (quoting 79 Fed. Reg. 49854, 50018 (Aug. 22, 2014)).
[38] *Id.* One provider had a cost report for the six-month period from July 1, 2011 to December 31, 2011 and another for the twelve-month period from July 1, 2012 to June 30, 2013, while the second had a cost report for the nine-

hospital's shorter cost reporting period in calculating the Factor 3 values for their FY 2015 DSH payments.[39]

In *Scranton*, the providers argued that, unlike the providers in *Tampa General* and *DCH v. Azar* who were specifically attacking the methodology and policies adopted by the Secretary, they were simply trying to enforce those policies. The D.C. District Court was not persuaded, finding that the complaint was still about the method used and the particular data the Secretary chose to rely upon when estimating the amount of uncompensated care calculated. Just like in *Tampa General* and *DCH v. Azar*, the selection of one cost report for FY 2012 over another was "inextricably intertwined" with the Secretary's estimate in Factor 3 and not subject to administrative review. Similarly, the challenge to the decision to use one cost report over another was also a challenge to a "period selected by the Secretary," which is also barred from review.[40]

Finally, and perhaps most importantly, the D.C. District Court found that any allegations that the Secretary departed from her own policy and/or acted *ultra vires* did not alter its decision. The D.C. District Court found that, in the context of the bar on review of the Secretary's estimates used and periods chosen for calculating the factors in the UCC payment methodology, "saying that the Secretary wrongly departed from his own policies when he chose the data for the estimate or selected the period involved is fundamentally indistinguishable from a claim that he chose the wrong data or selected the wrong period."[41] While there is some case law to support that claims of *ultra vires* acts may be subject to review in narrow circumstances where such review is precluded by statute, the criteria in *Scranton* were not met.[42] For review to be available in these circumstances, the following criteria must satisfied:

> (i) the statutory preclusion of review is implied rather than express; (ii) there is no alternative procedure for review of the statutory claim; and (iii) the agency plainly acts in excess of its delegated powers and contrary to a specific prohibition in the statute that is clear and mandatory.[43]

The D.C. District Court found that the preclusion of review for this issue was express, not implied, which fails to satisfy the first prong of this test. Second, the departure from the period to be used announced in the Secretary's rulemaking does not satisfy the third prong, which requires a violation of a clear statutory command.[44] The D.C. District Court ultimately upheld the Board's decision that it lacked jurisdiction to consider the providers' appeals.

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month period from October 1, 2011 to June 30, 2012 and another for the twelve-month period from July 1, 2012 to June 30, 2013.

[39] *Id.*

[40] *Id.* at 262-64.

[41] *Id.* at 265.

[42] *Id.* (discussing *Leedom v. Kyne*, 358 U.S. 184, 188 (1958)).

[43] *Id.* at 264 (quoting *DCH v. Azar*, 925 F.3d at 509-510).

[44] *Id.* at 264-6511 (quoting *DCH v. Azar*, 925 F.3d at 509).

d. Ascension Borgess Hospital v. Becerra

Even more recently, the D.C. Circuit revisited, once again, the judicial and administrative bar on review of uncompensated care DSH payments again in *Ascension Borgess Hospital v. Becerra* ("*Ascension*").[45] In *Ascension*, the providers sought an order declaring the Worksheet S-10 audit protocol was unlawful, vacating the payments based on the Worksheet S-10 audit, requiring the Secretary to recalculate those payments, and setting aside the Board decisions refusing to exercise jurisdiction over their appeals.[46] Ultimately, the D.C. Circuit found that 42 U.S.C. § 1395ww(r)(3) bars administrative and judicial review of the providers claims. In making this finding, the D.C. Circuit pointed to its earlier decisions in *Tampa General* and *DCH v. Azar* where it "repeatedly applied a "functional approach" focused on whether the challenged action was " 'inextricably intertwined' with the unreviewable estimate itself" and eschewing "categorical distinction between inputs and outputs."[47] The D.C. Circuit further dismissed the applicability of the Supreme Court's 2019 decision in *Azar v. Allina Health Serv*s.[48] noting that "[t]he scope of the Medicare Act's notice-and-comment requirement would be relevant in evaluating the merits of plaintiffs' claims—i.e., that the Worksheet S-10 audit protocol establishes or changes a substantive legal standard within the meaning of § 1395hh(a)(2)—***but has no bearing on whether these claims are barred by the Preclusion Provision***."[49]

The Board finds that the same findings are applicable to the Provider's challenge to their FFY 2017 UCC payments. The Providers here are challenging their uncompensated care DSH Payment amounts, as well as the general rules governing the methodology used in calculating those amounts, for FFY 2017. The challenge to CMS' notice and comment procedures focuses on a lack of information and underlying data used by the Secretary to determine the UCC payments, but *Tampa General* held that the underlying data cannot be reviewed or challenged. Likewise, the Provider's arguments centering on the *Allina* decision claim that certain data should recalculated or revised. Again, a challenge to the underlying data used in calculating UCC DSH payments is not subject to administrative or judicial review. Likewise, any challenge to the methodology used to determine the payment amounts was rejected in *DSCH v. Azar*, finding that the methodology was just as "inextricably intertwined" with the actual estimates as the underlying data, and barred from review.

****

In summary, the Board hereby dismisses the DSH Payment/SSI Percentage (Provider Specific) issue from this appeal as it is duplicative of the issue in Case No. 20-1332GC and there is no final determination from which the Provider can appeal the SSI realignment portion of the issue. Finally, the Board dismisses the UCC Distribution Pool issue as the Board does not have jurisdiction because 42 U.S.C. § 1395ww(r)(3) and 42 C.F.R. § 412.106(g)(2) preclude administrative and judicial review of certain aspects of the UCC payment calculation. As no

[45] Civ. No. 20-139, 2021 WL 3856621 (D.D.C. August 30, 2021).
[46] *Id*. at *4.
[47] *Id*. at *9.
[48] 139 S. Ct. 1804 (2019).
[49] *Ascension* at *8 (bold italics emphasis added).

issues remain pending, the Board hereby closes Case No. 19-2656 and removes it from the Board's docket.

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

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For the Board:

3/26/2024

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RE: ***Board Decision*** **– SSI Percentage (Provider Specific) and Medicaid Eligible Days**
Memorial Hospital of Salem County (Provider Number 31-0091)
FYE: 12/31/2010
Case Number: 19-2773

Dear Mr. Summar and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the documentation in the above referenced appeal. The decision of the Board is set forth below.

Background:

The Provider was issued a Notice of Reopening dated July 17, 2017, which stated:

> We received your request for a recalculation of the hospital's Supplemental Security Income/Medicare Part A percentage. We forwarded the request to the Centers for Medicare and Medicaid Services (CMS). When we receive a response from CMS, we will recalculate the hospital's disproportionate share adjustment, if necessary.

On March 6, 2019, the Provider was issued a Revised Notice of Program Reimbursement ("RNPR") for fiscal year end December 31, 2010. It included the following adjustments:

#5, 6, and S-D: Adjustments related to the SSI Percentage Realignment

On August 28, 2019, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained three (3) issues:

1. DSH Payment/SSI Percentage (Provider Specific)
2. DSH/SSI Percentage (Systemic Errors)[1]
3. DSH Payment – Medicaid Eligible Days

On December 9, 2019, the Medicare Contractor filed a jurisdictional challenge, requesting the dismissal of all issues.[2] The Provider responded to the challenge on January 7, 2020.

[1] On March 20, 2020, this issue was transferred to PRRB Case No. 18-1832GC.
[2] As stated above, Issue 2 was transferred to PRRB Case No. 18-1832GC on March 20, 2020.

On April 22, 2020, the Provider submitted its preliminary position paper.

On August 13, 2020, the Medicare Contractor filed its preliminary position paper.

MAC's Contentions

Issue 1 – DSH Payment/SSI Percentage (Provider Specific)

The MAC argues that the Board lacks jurisdiction over the DSH – SSI Percentage (Provider Specific) issue for two reasons. First, the MAC argues that the SSI realignment portion of the issue has already been performed:

> The decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election. It is not a final intermediary determination. A hospital must make a formal request to CMS in order to receive a realigned SSI percentage. Once the hospital elects to use its own fiscal year end, it is bound by that decision, regardless of reimbursement impact.
>
> . . .
>
> In this case, the provider has already requested, and the MAC has already implemented the realignment of the SSI percentage with the NCPR [Notice of Corrected Program Reimbursement] from which this appeal is based upon (see Exhibit C-1). Hence, the Provider has already received the remedy it seeks in this appeal.[3]

In addition, the MAC argues the DSH – SSI Percentage (Provider Specific) issue and the DSH – SSI Percentage (Systemic Errors) issue are duplicates.[4]

Issue 2: DSH – SSI Percentage

The MAC contends that Issue 2 should be dismissed because it is a duplicate of the Provider's appeal in PRRB Group cases #13-1162GC.[5]

Issue 3 – DSH Payment – Medicaid Eligible Days

The MAC argues that the Board lacks jurisdiction of the Medicaid Eligible Days issue because the issue in dispute was not adjusted in the NCPR (or RNPR).[6]

---

[3] Jurisdictional Challenge at 6-7 (Dec. 9, 2019).
[4] *Id*. at 5-6.
[5] This issue was subsequently transferred to a group appeal.
[6] *Id*. at 11.

Provider's Jurisdictional Response

Issue 1 – DSH SSI Percentage (Provider Specific)

The Provider argues that the issues are not duplicative because "issues #1 and 2 represent different components of the SSI issue, which was specifically adjusted during the audit."[7] Additionally, the Provider argues that the issue is not duplicative because the Provider is "not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category."[8]

Finally, the Provider contends the Provider Specific issue is appealable "because the MAC specifically adjusted the Provider's SSI percentage and the Provider is dissatisfied with the amount of DSH payments that it received for fiscal year 2010 resulting from its understated SSI percentage due to errors of omission and commission."[9]

Issue 2- SSI Percentage

The response filed by the Provider for this issue was simply an explanation of the issue, and included no discussion as to why it should not be dismissed.

Issue 5 – Medicaid Eligible Days

The Provider argues the MAC specifically adjusted DSH, and this "adjustment was enough to warrant Board Jurisdiction over this appeal issue. However, the Provider contends that the adjustment is not required, as DSH is not an item that has to be adjusted or claimed on a cost report. Accordingly, the presentment requirement is not valid. The Provider respectfully requests that the Board find it has jurisdiction over this Provider."[10]

Board Analysis and Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), 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 Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885, which provides in relevant part:

> (a) General. (1) A Secretary determination, a contractor determination, or a decision by a reviewing entity (as described in §

[7] Jurisdictional Response at 1 (Jan 7, 2020).
[8] *Id*. at 2.
[9] *Id*.
[10] *Id*. at 3.

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

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

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.[11]

Further, this regulatory limitation is cross-referenced in the provider's right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.

[11] 42 C.F.R. § 405.1889(b).

> (3) 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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[12]

The Provider appealed from an RNPR, specifically adjusting the SSI percentage due to a request, by the Provider, to realign the SSI percentage to the Provider's FYE. Regarding the SSI percentage realignment, the Code of Federal Regulations at 42 C.F.R. § 412.106(b)(3) limits this action to once per cost reporting period:

> (3) ***First computation: Cost reporting period.*** If a hospital prefers that CMS use its cost reporting period instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. ***This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period.***[13]

As noted in 42 C.F.R. § 412.106(b)(2), CMS gathers data to be used in the SSI fraction on a month-by-month basis:

> (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

[12] (Emphasis added).
[13] (Bold and italic emphasis added).

Medicare Advantage (Part C)).[14]

The data matching process by which CMS gathers this monthly data is described in the FY 2011 IPPS Final Rule.[15] As described in the Federal Register, under the realignment process, CMS calculates the SSI fraction using the *previously-gathered* data for the months included in the published SSI fractions for 2 Federal fiscal years that encompass the hospital's cost reporting period:

1. *75 Fed. Reg. 50042, 50279 (Aug. 16, 2010)*.—"[W]e publish these [SSI fraction] data for every hospital based on the Federal fiscal year but, under the regulations at § 412.106(b)(3), a hospital with a cost reporting period that differs from the Federal fiscal year may request a revised SSI fraction that is based on its own cost reporting period rather than the Federal fiscal year. In such a case, we would revise the hospital's SSI fraction using SSI and Medicare data derived f*rom the data match process* ***for the two Federal fiscal years thatspanned the hospital's cost reporting period***."[16]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether ornot it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*[17]

   Beginning with cost reporting periods that include December 8, 2004 (within one year of the date of enactment of Pub. L. 108–173), we will arrange to furnish, consistent with the Privacy Act, MedPAR LDS data for a hospital's patients eligible for both SSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal relating to DSH payments. *We will make the information available for either the Federal fiscal year or, if the hospital's fiscal year differs from the Federal fiscal year, for the* ***months included in the 2 Federal fiscal years that encompass the hospital's cost reporting period***. Under this provision, *the hospital will be able to use these data to calculate and verify its Medicare fraction, and to decide whether it prefers to have the fraction determined on the basis of its fiscal year rather than a Federal fiscal year*. The data set made available to hospitals will be the ***same data set*** CMS uses to calculate the Medicare fractions for the Federal fiscal year."[18]

As for the three issues under appeal in this case, the Board finds it does not have jurisdiction over issue #1, as the realignment portion of the SSI percentage has already been performed. To the extent that the sub-issue of #1 is duplicative of issue #2, that will be addressed below.

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[14] (Emphasis Added.)
[15] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[16] (Emphasis Added.)
[17] (Emphasis Added.)
[18] (Emphasis Added.)

For Issue #2, the Board finds that it does not have jurisdiction over the SSI Accuracy issue for Salem County as they appealed from an RNPR which was issued as a result of the Provider's SSI Realignment request, and did not adjust the Baystate Data Match or omissions issue as described in the issue statements. Pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those mattersthat are specifically revised[.]"[19] As a result, the Provider does not have the right to appeal this determination under 42 C.F.R. § 405.1889(b), as referenced in §405.1835(a)(1).

The realignment process does not change any of the data underlying the realigned SSI fraction because that data had been *previously* gathered on a month-by-month basis and *there is no need for CMS to rerun the data matching process* in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year and does not use any data matching process to achieve the new SSI value). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provide "must accept" the realigned SSI percentage.

Since the only matter specifically revised in the RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider does not have a right to appeal the SSI Accuracy issue under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). That issue should have been appealed from the original NPR. The Board hereby dismisses issue #2 (and any duplicative sub-issue in #1) and hereby denies the transfer of the dismissed issue(s) to 18-1832GC. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[20]

For Issue #3, the Board finds that it does not have jurisdiction over the DSH Payment – Medicaid Eligible Days issue that were appealed from the RNPR. Similar to Issue #2, the Board finds that the RNPR for this Provider was issued as a result of SSI Realignment requests, and the RNPR did not adjust the Medicaid Eligible Days. Thus, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

****

In summary, the Board hereby dismisses all three issues appealed from the RNPR. The Provider appealed from a Realigned SSI percentage, and therefore has no right, per regulation, to request a new realignment. Issues 2 and 3 were not adjusted in the RNPR. The transfer of issue #2 is also denied to PRRB Group Case 18-1832GC. As no issues remain pending, the Board hereby closes Case No. 19-2773 and removes it from the Board's docket.

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

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[19] 42 C.F.R. § 405.1889(b)(1).

[20] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*,No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020)*, Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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For the Board:

3/27/2024

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RE: ***Expedited Judicial Review Decision***
Case No. 23-1210G – Bass, Berry & Sims, PLC CY 2020 Capital DSH Group
Case No. 23-1645GC – Main Line Health CY 2020 Capital DSH CIRP Group

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the February 26, 2024 consolidated request for expedited judicial review[1] ("EJR") for the above-referenced optional and common issue related party ("CIRP") group appeals. The decision with respect to EJR is set forth below.[2]

Issue under Dispute

In these group cases, the Providers are challenging:

> [t]he validity of the regulation at 42 C.F.R. § 412.320(a)(1)(iii), which bars hospitals that are geographically urban and reclassify as rural under 42 C.F.R. § 412.103 from receiving a capital disproportionate share hospital ("DSH") add-on payment, known as the capital DSH adjustment. The Providers challenge the validity of 42 C.F.R. § 412.320(a)(1)(iii) on a number of grounds including that the regulation (a) is inconsistent with the controlling Medicare statute, (b) was adopted in violation of the Administrative Procedure Act, and (c) is arbitrary and capricious.[3]

Background:

Under the inpatient prospective payment system ("IPPS"), Medicare pays hospitals predetermined rates for patient discharges and this system is comprised of two parts, one for operating costs ("operating IPPS") as set forth at § 1395ww(d); and one for capital costs ("capital IPPS") as set forth at 42 U.S.C. § 1395ww(g). The primary objective of IPPS is to

[1] Providers' Petition for Expedited Judicial Review (Feb. 26, 2024) ("Request for EJR").
[2] The Request for EJR encompasses six (6) group cases. On March 19, 2024, the Board issued a Request for Information and Scheduling Order in Case Nos. 23-0926G, 23-0701G, 23-1514GC, and 24-1269GC. That order stayed the 30-day period for the Board to rule on the Request for EJR in those cases and, as a result, the instant decision does not relate to those four (4) group cases.
[3] Request for EJR at 1.

create incentives for hospitals to operate efficiently, while providing adequate compensation to hospitals.[4] This case focuses on the capital IPPS.

1. Geographic Reclassification

In 1989, Congress created the Medicare Geographic Classification Review Board ("MGCRB") which implemented a geographic reclassification system in which IPPS hospitals can be reclassified to a different wage index area[5] for purposes of receiving a higher payment rate if they meet certain criteria related to proximity and average hourly wage.[6] This includes an IPPS hospital reclassifying from a rural to an urban labor market, or vice versa.

2. Operating DSH Adjustment Under Operating IPPS

Part A of the Medicare Act covers "inpatient hospital services." Since 1983, the Medicare program has paid most hospitals for the operating costs of inpatient hospital services under operating IPPS.[7] Under the operating IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[8]

The statute governing operating IPPS contains a number of provisions that adjust reimbursement based on hospital-specific factors.[9] One of the adjustments is the hospital-specific Disproportionate Share Hospital ("DSH") adjustment as set forth at 42 U.S.C. § 1395ww(d)(5)(F), which requires the Secretary to provide an adjustment (*i.e.*, an increase in the operating IPPS payment) to hospitals that serve a significantly disproportionate number of low-income patients.[10]

A hospital may qualify for a DSH adjustment to its operating IPPS payments based on its disproportionate patient percentage ("DPP").[11] As a proxy for utilization by low-income patients, the DPP determines a hospital's qualification as a DSH, and it also determines the amount of the DSH payment to a qualifying hospital.[12]

---

[4] Daniel R. Levinson, Department of Health and Human Services, Office of the Inspector General, *Significant Vulnerabilities Exist in the Hospital Wage Index System for Medicare Payments*, 1 (Nov. 2018), *available at* https://oig.hhs.gov/oas/reports/region1/11700500.pdf (last visited Oct. 20, 2022) ("*Significant Vulnerabilities*").
[5] *See* https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/wageindex.html (42 U.S.C. § 1395ww(d)(3)(E) requires that, as part of the methodology for determining prospective payments to hospitals, the Secretary must adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget and announced in December 2003. The wage index also reflects the geographic reclassification of hospitals to another labor market area, such as rural to urban or vice versa, in accordance with sections 1395ww(d)(8)(B) and 1395ww(d)(10).).
[6] Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 103 Stat. 2106, 2154 (1989). *See also Significant Vulnerabilities* at 4-5.
[7] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[8] *Id.*
[9] *See* 42 U.S.C. § 1395ww(d)(5).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I) and (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[12] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv) and (vii)-(xiii); 42 C.F.R. § 412.106(d).

The DSH adjustment provided under operating IPPS is ***not*** at issue in this case. However, the DSH adjustment is relevant because the Secretary applies certain standards set forth in 42 U.S.C. § 1395ww(d)(5)(F) for the DSH adjustment to the capital DSH adjustment made under capital IPPS.

3. Capital DSH Adjustment Under Capital IPPS

A hospital's *capital* costs are paid separately under capital IPPS (*i.e.*, separate and apart from payment for a hospital's *operating* costs under the operating IPPS). Specifically, on December 22,1987, Congress enacted the Omnibus Budget Reconciliation Act of 1987 ("OBRA-87") and OBRA-87 § 4006(b) required the Secretary to establish the capital IPPS for cost reporting periods beginning in FY 1992.[13] OBRA-87 § 4006(b) was codified at 42 U.S.C. § 1395ww(g) which states, in pertinent part:

> **(g) Prospective payment for capital-related costs; return on equity capital for hospitals**
>
> (1)(A) Notwithstanding section 1395x(v) of this title, instead of any amounts that are otherwise payable under this subchapter with respect to the reasonable costs of subsection (d) hospitals and subsection (d) Puerto Rico hospitals for capital-related costs of inpatient hospital services, the Secretary *shall,* for hospital cost reporting periods beginning on or after October 1, 1991, *provide for payments for such costs* in accordance with a prospective payment system established by the Secretary. . . .
>
> (B) Such system— (i) shall provide for (I) a payment on a per discharge basis, and (II) an appropriate weighting of such payment amount as relates to the classification of the discharge;
>
> (ii) *may provide for <u>an adjustment</u> to take into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located*;
>
> (iii) may provide for such exceptions (including appropriate exceptions to reflect capital obligations) as the Secretary determines to be appropriate, and
>
> (iv) may provide for suitable adjustment to reflect hospital occupancy rate.
>
> (C) In this paragraph, the term ''capital-related costs'' has the meaning given such term by the Secretary under subsection (a)(4)

[13] Pub. L. 100-203, § 4006(b), 101 Stat. 1330, 1330-52 (1987).

> as of September 30, 1987, and does not include a return on equity capital.[14]

Significantly, the statute governing capital IPPS does not specifically mandate or address the use of a capital DSH adjustment. Rather, it specifies generally that the Secretary "may provide for an adjustment to account variations in relative costs." As described below, the Secretary exercised his discretion to establish the c*apital* DSH adjustment at issue in this case which is limited in that it ***only*** applies to *urban* hospitals with 100 or more beds and that serve low income patients.[15]

1. Initial Implementation of Capital IPPS and the Capital DSH Adjustment

To the end, the Secretary published a final rule on August 30, 1991 to establish the capital IPPS.[16] In implementing the capital IPPS, the Secretary recognized that he had discretion on whether to apply many of the adjustments statutorily required under operating IPPS to capital IPPS:

> We are persuaded by the argument advanced by some commenters, including ProPAC, that in the long run the ***same*** adjustments should be applied to capital and operating payments and that the level of the adjustments should be determined by examining combined operating and capital costs. ProPAC recommended that the unified adjustments be calculated within two years. However, we believe that it would be most appropriate to implement these adjustments with respect to the capital prospective payment systems from the outset. *While the payment adjustments for the operating prospective payment system are determined by the Act (and therefore cannot be modified by the rulemaking process),* ***we have the latitude to develop adjustments based on combined costs for the capital prospective payment system***.
>
> We do not believe that it would be appropriate to use the current operating payment adjustments in the capital prospective payment system either permanently or on an interim basis until legislation is enacted changing the operating adjustments to the level appropriate for total costs. This is because the levels of the operating payment adjustments for serving a disproportionate share of low income patients (DSH) and for indirect medical education costs (IME) exceed the levels supported by empirical analysis. We believe the payment adjustments should be empirically supported and should reflect only the higher Medicare costs associated with teaching activity and treating low income patients.[17]

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[14] (Underline and italics emphasis added.)
[15] 42 C.F.R. § 412.320(a)(1). *See also* MedPAC, *Hospital Acute Inpatient Services Payment System: Payment Basics*, 2 (rev. Nov. 2021), *available at* https://www.medpac.gov/wp-content/uploads/2021/11/medpac_payment_basics_21_hospital_final_sec.pdf (last visited Oct. 20, 2022).
[16] 56 Fed. Reg. 43356 (Aug. 30, 1991).
[17] *Id.* at 43369-70 (emphasis added).

The Secretary did adopt a limited DSH adjustment to capital IPPS for urban hospitals with more than 100 beds. The proposal was described as follows:

> In the proposed rule, our regression results indicated that for urban hospitals with more than 100 beds, the disproportionate share percentage of low income patients has an effect on capital costs per case. We proposed that urban hospitals with 100 or more beds would receive an additional payment equal to ({1 +DSHP)$^{0\text{-}4176}$ - 1)), where DSHP is the disproportionate share patient percentage. There would be no minimum disproportionate share patient percentage required to qualify for the payment adjustment. A hospital would receive approximately a 4.2 percent increase in payments for each 10 percent increase in its disproportionate share percentage. This formula is similar to the one used for the indirect medical education adjustment under the operating prospective payment system.
>
> Since we did not find a disproportionate share effect on the capital costs of urban hospitals with fewer than 100 beds or on rural hospitals, we did not propose to make a disproportionate share adjustment to the capital payment to these hospitals.[18]

In adopting his proposal, the Secretary gave the following justification:

> *Comment*: Many commenters believe that the disproportionate share patient percentage of 30 percent needed to qualify for the special exceptions payment under the proposal is too restrictive. Most of these commenters supported the use of 20.2 percent as the patient threshold percentage since that is the patient percentage above which operating disproportionate share payments become more generous. Some believe that any hospital that received DSH payments under the operating system should be eligible for the special exception.
>
> *Response*: In the final rule, we are providing that urban hospitals with 100 or more beds and a disproportionate share patient percentage of 20.2 percent or higher will be eligible to receive exceptions payments based on a higher minimum payment level than other hospitals. For FY 1992, the minimum payment level is 80 percent. Urban hospitals with 100 or more beds that receive disproportionate share payments under § 412.106(C)(2) would also be eligible for the higher minimum payment level. We are not extending the special protection to other hospitals that receive disproportionate share payments under the operating prospective payment system. In urban areas, we believe that our criteria properly focuses on those hospitals that serve a large disproportionate share population. Other urban hospitals receiving disproportionate share

[18] *Id* at 43377.

> payments tend to serve fewer low income patients either because of their smaller size (i.e., under 100 beds) or lower disproportionate share patient percentage. **In rural areas, we believe the more relevant criteria for determining whether a hospital should receive special payment protection is whether the hospital represents the sole source of care reasonably available to Medicare beneficiaries**.[19]

In response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to rural hospitals with 500 or more beds:

> As part of our regression analysis for this final rule, we examined the relationship between total cost per case and disproportionate share patient percentages for rural hospitals with at least 500 beds, and found no statistically significant relationship. As a result, we are not implementing any disproportionate share adjustment to prospective payments for capital for these hospitals. Hospitals that qualify for additional operating disproportionate share payments under section 1886(d)(5)(F)(i)(II) of the Act will be deemed to have a disproportionate patient percentage equivalent to that which would generate their operating disproportionate share payment, using the formula for urban hospitals with at least 100 beds. For discharges occurring on or after October 1,1991, these hospitals qualify for an operating adjustment of 35 percent, which is equivalent to having a disproportionate share patient percentage of 65.4. Urban hospitals with more than 100 beds that qualify for additional operating disproportionate share payments under section 1866(d)(5)(F)(i)(II) of the Act will be deemed to qualify for additional capital disproportionate share payments as well at the level consistent with their deemed disproportionate share patient percentage. The disproportionate share adjustment factor for these hospitals is 14.16 percent. The additional capital disproportionate share payments to these hospitals will be made at the same time that the additional operating disproportionate share payments are, that is, as the result of the application by these hospitals for payments under § 412.106(b)(l){ii) of the regulations.[20]

Similarly, in response to comments, the Secretary rejected expanding the application of the capital DSH adjustment to other classes of hospitals such as "[a]ll small urban hospitals, hospitals with high Medicare usage, rural hospitals, rural hospitals with at least 100 beds, rural referral centers, or those hospitals with high 'total government' usage":

> In developing the capital disproportionate share adjustment for this final rule, we examined the relationship between the

[19] *Id.* at 43409-10 (bold and underline emphasis added).
[20] *Id.*

> disproportionate share patient percentage and total costs per case for each class of hospital that is currently receiving an operating payment adjustment. We believe that only those hospitals that merit the adjustment according to our regression analysis should receive additional capital payments for serving low income patients. The regression results did not indicate any significant relationship between total costs per case and disproportionate share patient percentage for any of the special groups mentioned above.[21]

In response to comments, the Secretary also looked at setting a threshold DSH percentage to qualify for a capital DSH adjustment but rejected that alternative approached based upon the following explanation:

> We examined closely the possibility of using a disproportionate share patient percentage threshold in our total cost regression analysis. We were unable to find any threshold level of disproportionate share percentage below which no payment adjustment was merited, or a threshold above which a higher adjustment was merited. As a result, we believe that it is most equitable to make a capital disproportionate share payment to all qualifying hospitals with a positive patient percentage, rather than penalize some hospitals that have a higher cost of treating low income patients but whose patient percentage is below the artificial level we would set.[22]

Further, in response to comments, the Secretary rejected not providing *any* capital DSH adjustment based on the explanation:

> We disagree with the commenter. The regression analyses show that serving low income patients (as defined in section 1886(d)(5)(F)(vi) of the Act) results in higher Medicare capital and total costs per case *for urban hospitals with at least 100 beds*. We believe that it is appropriate for Medicare's payment to recognize these higher Medicare patient care costs.[23]

Finally, the Secretary addressed how MGCRB reclassifications, in certain circumstances, affect whether an IPPS hospital qualifies for the capital DSH adjustment:

> *Comment*: Many commenters sought clarification of the effect of reclassification by the Medicare Geographic Classification Review Board (MGCRB) on eligibility for capital disproportionate share payments.

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[21] *Id.* at 43378.
[22] *Id.* at 43379.
[23] (Emphasis added.)

> *Response*: Any hospital that is reclassified to an urban area by the MGCRB for purposes of its standardized amount is considered to be urban for all prospective payment purposes other than the wage index. As such, if any hospital reclassified by the MGCRB to an urban area for purposes of the standardized amount has at least 100 beds, it would be eligible for capital disproportionate share payments. We note that a rural hospital reclassified for purposes of the wage index only is still considered a rural hospital, and as such, will not be eligible for capital disproportionate share payments.

The resulting regulations governing capital IPPS were codified at 42 C.F.R. Part 412, Subpart M (§§ 412.300 to 412.374). The regulation governing the capital DSH adjustment was codified at § 412.320 which, at initial implementation, stated:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area, has 100 or more beds as determined in accordance with § 412.105(b) and serves low-income patients, as determined under § 412.106(b), or if the hospital meets the criteria in § 412.106(c)(2).
>
> (b) *Payment adjustment factor*. (1) <u>If a hospital meets the criteria in paragraph (a) of this section for a disproportionate share hospital for purposes of capital prospective payments</u>, the disproportionate share payment adjustment factor equals [e raised to the power of (.2025 X the hospital's disproportionate patient percentage as determined under § 412.106(b)(5)), —1], where e is the natural antilog of 1.
>
> (2) If a hospital meets the criteria in § 412.106(c)(2) for purposes of inpatient hospital operating prospective payments, the disproportionate share adjustment factor equals 14.16 percent.[24]

2. *Reclassification of Certain IPPS Urban Hospitals as Rural for Purposes of Operating IPPS Pursuant to BBRA § 401 and Impact on Capital IPPS Adjustments*

On November 29, 1999, Congress enacted the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA") and BBRA § 401 amended 42 U.S.C. § 1395ww(d)(8) to require that certain urban IPPS hospitals be reclassified as rural *for purposes of operating IPPS* if an application is submitted to the MGCRB and certain criteria are met.[25] IPPS hospitals are reclassified per BBRA § 401 are often referred to as "§ 401 hospitals."

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[24] *Id*. at 43452-53.
[25] BBRA, Pub. L. 106-113, App. F, § 401, 113. Stat. 1501A-321, 1501A-369 (1999).

On August 1, 2000, the Secretary published the interim final rule to, in part, implement BBRA § 401 and stated in the preamble that a hospital reclassified as rural pursuant to § 401 is treated as rural for ***all*** purposes under operating IPPS, including the DSH adjustment for operating IPPS:

> *A hospital that is reclassified as rural* under section 1886(d)(8)(E) of the Act, as added by section 401(a) of Public Law 106–113, ***is treated as rural for all purposes*** *of payment under the Medicare inpatient hospital prospective payment system* (section 1886(d) of the Act), *including* standardized amount (§§ 412.60 et seq.), wage index (§ 412.63), and ***disproportionate share calculations*** (§ 412.106) as of the effective date of the reclassification.[26]

On August 1, 2000, the Secretary also published the FY 2001 IPPS Final Rule which included the following discussion on the effect of reclassification of a hospital from urban to rural pursuant to BBRA § 401:

> In the May 5, 2000 proposed rule, we indicated that we are concerned that section 1886(d)(8)(E) might create an opportunity for some urban hospitals to take advantage of the MGCRB process by first seeking to be reclassified as rural under section 1886(d)(8)(E) (and receiving the benefits afforded to rural hospitals) and in turn seek reclassification through the MGCRB back to the urban area for purposes of their standardized amount and wage index and thus also receive the higher payments that might result from being treated as being located in an urban area. ***That is, we were concerned that some hospitals might inappropriately seek to be treated as being located in a rural area for some purposes and as being located in an urban area for other purposes***. In light of the Conference Report language noted above discussing the House bill and what appears to be the potential for inappropriately inconsistent treatment of the same hospital on the other hand, in the May 5 proposed rule, we solicited public comment on this issue, and indicated that we might impose a limitation on such MGCRB reclassifications in this final rule for FY 2001, if such action appears warranted. We also sought specific comments on how such a limitation, if any, should be imposed and provided several examples and alternatives.
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>
> Consistent with the statutory language, we are providing that a hospital reclassified as rural under section 1886(d)(8)(E) of the Act will be treated as being located in a rural area for purposes of section 1886(d) of the Act, and cannot subsequently be reclassified under the MGCRB process to an urban area (in order to be treated

[26] 65 Fed. Reg. 47026, 47030 (Aug. 1, 2000) (emphasis added.)

as being located in an urban area for certain purposes under section 1886(d) of the Act).

This policy is consistent not only with the statutory language but also with the policy considerations underlying the MGCRB process. The MGCRB process permits a hospital to be reclassified from one geographic area to another if it is significantly disadvantaged by its geographic location and would be paid more appropriately if it were reclassified to another area. We believe that it would be illogical to permit a hospital that applied to be reclassified from urban to rural under section 1886(d)(8)(E) of the Act because it was disadvantaged as an urban hospital to then utilize a process that was established to enable hospitals significantly disadvantaged by their rural or small urban location to reclassify to another urban location. *If an urban hospital applies under section 1886(d)(8)(E) of the Act in order to be treated as being located in a rural area, then it would be anomalous at best for the urban hospital to subsequently claim that it is significantly disadvantaged by the rural status for which it applied and should be reclassified to an urban area. Furthermore, permitting hospitals the option of seeking rural reclassification under section 1886(d)(8)(E) of the Act for certain payment advantages, coupled with the ability to pursue a subsequent MGCRB reclassification back to an urban area, could have implications beyond those originally envisioned under Public Law 106–113*. In particular, we are concerned about the potential interface between rural reclassifications under section 401 and section 407(b)(2) of Public Law 106– 113, which authorizes a 30-percent expansion in a rural hospital's resident full-time equivalent count for purposes of Medicare payment for the indirect costs of medical education (IME) under section 1886(d)(5)(B) of the Act. (Reclassification from urban to rural under section 1886(d)(8)(E) of the Act can affect IME payments to a hospital, which are made under section 1886(d)(5)(B) of the Act, but not payments for the direct costs of GME, which are made under section 1886(h) of the Act.)

Congress clearly intended hospitals that become rural under section 1886(d)(8)(E) of the Act to receive some benefit as a result. For example, some hospitals currently located in very large urban counties are in fact fairly small, isolated hospitals. Some of these hospitals will now be able to be designated a rural hospital and become eligible to be designated a critical access hospital.

****

We are not permitting hospitals redesignated as rural under section 1886(d)(8)(E) of the Act to be eligible for subsequent

> reclassification by the MGCRB, and are revising the regulations governing MGCRB reclassifications (§ 412.230) accordingly.
>
> ****
>
> *We wish to emphasize that urban to rural reclassification under section 1886(d)(8)(E) of the Act is entirely voluntary*. ***Each hospital anticipating that it may qualify under this provision should determine the impact of Medicare payment policies if it were to reclassify***. As discussed above, we believe that our policies here are consistent with the Secretary's broad authority under section 1886(d)(10) of the Act, the statutory language in section 1886(d)(8)(E) of the Act, as well as our understanding of the intent underlying the description of the House bill in the Conference Report.[27]

Thus, both the August 1, 2000 interim final rule and the FY 2001 IPPS Final Rule confirmed that urban hospitals reclassified as rural pursuant to BBRA § 401 would be treated as rural for all purposes of operating IPPS, including DSH adjustments. The Secretary memorialized this policy in regulation at 42 C.F.R. § 412.103 (2000) which states in pertinent part:

> **§ 412.103 Special treatment: Hospitals located in urban areas and that apply for reclassification as rural**.
>
> (a) *General criteria*. A prospective payment hospital that is located in an urban area (as defined in § 412.62(f)(1)(ii)) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
>
> 1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification as determined by the Office of Rural Health Policy (ORHP) of the Health Resources and Services Administration which is available via the ORHP website at http:// www.nal.usda.gov/orph or from the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy, 5600 Fishers Lane, Room 9–05, Rockville, MD 20857.
>
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.

[27] 65 Fed. Reg. 47054, 47088-89 (Aug. 1, 2000).

> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.[28]

Neither the August 1, 2000 interim final rule nor the FY 2001 IPPS Final Rule explicitly discussed the impact on capital DSH adjustments under capital IPPS. However, through operation of the cross-reference in 42 C.F.R. § 412.320(a) to § 412.63(a) in the phrase "the hospital is located, for purposes of receiving payment under § 412.63(a), in an urban area", the Board concludes that hospitals reclassified from urban to rural were ***not*** eligible for capital DSH adjustments under capital IPPS. In this regard, the Board notes that, following the 2000 rulemaking process, § 412.63(a)-(b) (2001) read, in pertinent part:

> (a) *General rule*. (1) HCFA determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in a Federal fiscal year after fiscal year 1984 involving inpatient hospital services of a hospital in the United States subject to the prospective payment system, and determines a regional adjusted prospective payment rate for operating costs for such discharges in each region, for which payment may be made under Medicare Part A.
>
> (2) **Each such rate is determined for hospitals located in urban or rural areas** within the United States and within each such region respectively, **as described in paragraphs (b)** through (g) of this section.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the definitions set forth in § 412.62(f) apply, **except that**, effective January 1, 2000, **a hospital reclassified as rural may mean** a reclassification that results from a geographic redesignation as set forth in § 412.62(f)(1)(iv) or **a reclassification that results from an urban hospital applying for reclassification as rural as set forth in § 412.103**.[29]

The specific reference in § 412.63(b) to urban to rural reclassifications made under § 412.103 makes clear that capital DSH adjustments would not apply to hospitals reclassified from urban to rural pursuant to BBRA § 401 which as noted above was implemented at § 412.103.

3. Changes to Operating IPPS Required by MMA § 401 and Their Effect on Capital IPPS

On December 8, 2003, Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 ("MMA") and MMA § 401 to equalize operating IPPS payments between urban and rural hospitals.[30] Specifically, § 401 specifies that, beginning with FY 2004,

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[28] *Id*. at 47048.
[29] (Italics emphasis in original and bold and underline emphasis added.)
[30] Pub. L. 108–173

all IPPS hospitals are paid on the basis of the large urban standardized amount under operating IPPS.

The Office of Management and Budget publishes information on core-based statistical areas ("CBSAs") and the Secretary has used this information for purposes of defining labor market areas for use in the wage index for operating IPPS.[31] On June 6, 2003, OMB announced the new CBSAs, comprised of metropolitan statistical areas ("MSAs") and the new Micropolitan Areas based on Census 2000 data.[32]

On August 11, 2004, the Secretary published the FY 2005 IPPS Final Rule and this rule finalized revisions to the operating IPPS regulations to both implement MMA § 401 as well as adopt OMB's new CBSA designations.[33] With respect to implementing MMA § 401, the Secretary revised 42 C.F.R. § 412.63 to apply only to years through 2004 and added a new § 412.64 to implement MMA § 401 for federal rates for FYs 2005 forward. Specifically, § 412.64 reads in pertinent part:

> **§ 412.64 Federal rates for inpatient operating costs for Federal fiscal year 2005 and subsequent fiscal years.**
>
> (a) *General rule*. CMS determines a national adjusted prospective payment rate for inpatient operating costs for each inpatient hospital discharge in Federal fiscal year 2005 and subsequent fiscal years involving inpatient hospital services of a hospital in the United States subject to the prospective payment system for which payment may be made under Medicare Part A.
>
> (b) *Geographic classifications*. (1) For purposes of this section, the following definitions apply:
>
> (i) The term region means one of the 9 metropolitan divisions comprising the 50 States and the District of Columbia, established by the Executive Office of Management and Budget for statistical and reporting purposes.
>
> (ii) The term *urban area* means—
>
> (A) A Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget; or
>
> (B) The following New England counties, which are deemed to be parts of urban areas under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21, 42 U.S.S. 1395ww (note)): Litchfield County, Connecticut; York County, Maine;

[31] 69 Fed. Reg. 48916, 49026 (Aug. 11, 2004).
[32] *Id.*
[33] 69 Fed. Reg. 48916 (Aug. 11, 2004).

> Sagadahoc County, Maine; Merrimack County, New Hampshire; and Newport County, Rhode Island.
>
> (C) The term *rural area* means any area outside an urban area.
>
> (D) The phrase *hospital reclassified as rural* means a hospital located in a county that, in FY 2004, was part of an MSA, but was redesignated as rural after September 30, 2004, as a result of the most recent census data and implementation of the new MSA definitions announced by OMB on June 6, 2003.
>
> (2) For hospitals within an MSA that crosses census division boundaries, the MSA is deemed to belong to the census division in which most of the hospitals within the MSA are located.
>
> (3) For discharges occurring on or after October 1, 2004, a hospital located in a rural county adjacent to one or more urban areas is deemed to be located in an urban area and receives the Federal payment amount for the urban area to which the greater number of workers in the county commute if the rural county would otherwise be considered part of an urban area, under the standards for designating MSAs if the commuting rates used in determining outlying counties were determined on the basis of the aggregate number of resident workers who commute to (and, if applicable under the standards, from) the central county or central counties of all adjacent MSAs. These EOMB standards are set forth in the notice of final revised standards for classification of MSAs published in the Federal Register on December 27, 2000 (65 FR 82228), announced by EOMB on June 6, 2003, and available from CMS, 7500 Security Boulevard, Baltimore, Maryland 21244.
>
> (4) For purposes of this section, any change in an MSA designation is recognized on October 1 following the effective date of the change. Such a change in MSA designation may occur as a result of redesignation of an MSA by the Executive Office of Management and Budget.[34]

Significantly, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

The Secretary also amended 42 C.F.R. § 412.320(a). As previously noted, § 412.320(a) originally only referenced § 412.63: "A hospital is classified as a 'disproportionate share hospital' for the purposes of capital prospective payments if the hospital is located, *for purposes*

[34] *Id.* at 49242. *See also id.* at 49103 (discussing implementation of MMA § 401).

of receiving payment under § 412.63(a), in an urban area."[35] As a result of the FY 2005 IPPS Final Rule, § 412.320(a) was updated to reference § 412.64 as it relates to FYs 2005 forward:

> **§ 412.320 Disproportionate share adjustment factor.**
>
> (a) *Criteria for classification*. A hospital is classified as a ''disproportionate share hospital'' for the purposes of capital prospective payments if either of the following conditions is met:
>
> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64.[36]

Again, as previously noted, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).

Finally, in the preamble to the FY 2005 IPPS Final Rule, the Secretary included the following discussion on the impact of the new CBSAs on geographic reclassifications:

> Currently, the large urban location adjustment under § 412.316(b) and the DSH adjustment for certain urban hospitals under § 412.320 for payments for capital-related costs rely on the existing geographic classifications set forth at § 412.63. Because we proposed to adopt OMB's new CBSA designations for FY 2005 and thereafter, under proposed new § 412.64, we proposed to revise § 412.316(b) and § 412.320(a)(1) to specify that, for discharges on or after October 1, 2004, the payment adjustments under these sections, respectively, would be based on the geographic classifications at proposed new § 412.64.
>
> ****
>
> The commenter is correct that as a result of the implementation of the new MSA definitions, hospitals that had previously been located in a large urban area under the current MSA definitions, but will now be located in another urban or rural area under the new MSA definitions will no longer qualify for certain payment

[35] (Emphasis added.)
[36] 42 C.F.R. § 412.320 (2004) (underline emphasis added). *See also* 69 Fed. Reg. at 49250.

> adjustments that they previously qualified for under the prior MSA definitions, including the 3-percent large urban add-on payment adjustment at § 412.312(b)(2)(ii) and § 412.316(b). As discussed previously, in the May 18, 2004 proposed rule, we solicited comments on the effect of the equalization of the operating IPPS standardized amount. Specifically, we discussed that rural and other urban hospitals that were previously eligible to receive the large urban add-on payment adjustment (and DSH payment adjustment) under the IPPS for capital-related costs if they reclassified to a large urban area for the purpose of the standardized amount under the operating IPPS, will no longer be reclassified and, therefore, will not be eligible to receive those additional payments under the IPPS for capital-related costs beginning in FY 2005. As we noted previously, we received no comments on that clarification.
>
> ****
>
> As previously discussed, we proposed and adopted as final our policy that, beginning in FY 2005 and thereafter, only those hospitals geographically located in a large urban area (as defined in revised § 412.63(c)(6)) will be eligible for the large urban add-on payment adjustment provided under § 412.312(b)(2)(ii) and § 412.316(b). *Similarly, beginning in FY 2005 and thereafter, to receive capital IPPS DSH payments under § 412.320, a hospital will need to be geographically located in an urban area (as defined in new § 412.64) and meet all other requirements of § 412.320.* Accordingly, we are adopting our proposed revisions as final without change.[37]

4. August 18, 2006 Revisions to the Capital DSH Adjustment

In the FY 2007 Proposed IPPS Rule, the Secretary[38] announced that he was proposing technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment. These proposed changes reflected the historic policy that hospitals reclassified as rural under § 412.103 also would be considered rural under the capital IPPS. Since the genesis of the capital IPPS in FY 1992, the same geographic classifications used under the operating IPPS also have been used under the capital IPPS.[39]

The Secretary believed that these proposed changes and clarifications were necessary because the agency's capital IPPS regulations had been updated to incorporate the Office of Management and Budget's ("OBM's") new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005.[40]

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[37] 69 Fed. Reg. 48916, 49187-88 (Aug. 11, 2004).
[38] of the Department of Health and Human Services.
[39] 71 Fed. Reg. 23995, 24122 (Apr. 25, 2006).
[40] *Id.*

In the FY 2007 IPPS Final Rule published on August 18, 2006, the Secretary finalized these technical changes to 42 C.F.R. §§ 412.316(b) and 412.320(a)(1) to clarify that hospitals reclassified as rural under § 412.103 are not eligible for the large urban add-on payment or for the capital DSH adjustment:

> These changes were proposed to reflect our historic policy that hospitals reclassified as rural under § 412.103 also are considered rural under the capital PPS. Since the genesis of the capital PPS in FY 1992, the same geographic classifications used under the operating PPS also have been used under the capital PPS.
>
> These changes and clarifications are necessary because we inadvertently made an error when we updated our capital PPS regulations to incorporate OMB's new CBSA definitions for IPPS hospital labor market areas beginning in FY 2005. In the FY 2005 IPPS final rule (69 FR 49187 through 49188), in order to incorporate the new CBSA designations and the provisions of the newly established § 412.64, which incorporated the CBSA-based geographic classifications, we revised § 412.316(b) and § 412.320 to specify that, effective for discharges occurring on or after October 1, 2004, the capital PPS payment adjustments are based on the geographic classifications under § 412.64. However, § 412.64 does not reference the provisions of § 412.103 regarding the urban-to-rural reclassifications, as was previously found in § 412.63(b)(1).
>
> We believe that this error must be corrected in order to maintain our historic policy for treating urban-to-rural hospital reclassifications under the operating PPS the same for purposes of the capital PPS. Therefore, we proposed to specify under §§ 412.316(b)(2) and (b)(3) and 412.320(a)(1)(ii) and (a)(1)(iii) that, for discharges on or after October 1, 2006, hospitals that are reclassified from urban to rural under § 412.103 would be considered rural.[41]

In adopting these changes, the Secretary noted that it did not receive any public comments on the proposed change as published in the proposed rule published on May 17, 2006.[42]

As a result of the FY 2007 IPPS Final Rule, the regulation, subparagraph (iii) was added to 42 C.F.R. § 412.320(a)(1) so that revised § 412.320(a) read, in pertinent part:

> (a) *Criteria for classification*. A hospital is classified as a "disproportionate share hospital" for the purposes of capital prospective payments if either of the following conditions is met:

[41] *Id.*
[42] *Id.*

> (1) The hospital is located in an urban area, has 100 or more beds as determined in accordance with § 412.105(b), and serves low-income patients as determined under § 412.106(b).
>
> (i) For discharges occurring on or before September 30, 2004, the payment adjustment under this section is based on a hospital's location, for the purpose of receiving payment, under § 412.63(a).
>
> (ii) For discharges occurring on or after October 1, 2004, the payment adjustment under this section is based on the geographic classifications specified under § 412.64, except as provided for in paragraph (a)(1)(iii) of this section.
>
> **(iii) For purposes of this section, the geographic classifications specified under § 412.64 apply, except that, effective for discharges occurring on or after October 1, 2006, for an urban hospital that is reclassified as rural as set forth in § 412.103, the geographic classification is rural.[43]**

5. *Litigation Challenging the Validity of 42 C.F.R. § 412.320(a)(1)(iii) as added by the FY 2007 IPPS Final Rule*

The validity of 42 C.F.R. § 412.320(a)(1)(iii) was addressed in *Toledo Hosp. v. Becerra* ("*Toledo*"),[44] wherein the hospital made the following contentions:

> Toledo Hospital contends that the Secretary's 2006 rulemaking is arbitrary and capricious and thus unreasonable for two principal reasons. First, it charges the Secretary with misrepresenting the regulatory history in claiming that the 2006 Rule merely restored a previously implemented policy. Second, the hospital argues that the Secretary failed to "take into account" relative costs of capital for various hospital types and areas of location, as subsection (g) requires.[45]

In *Toledo*, U.S. District Court for the District of Columbia ("D.C. District Court") outlined the legislative history surrounding the creation of the MGCRB in 1989 which, as noted above, can redesignate IPPS hospitals to different labor market areas in order to receive a different wage reimbursement rate.[46] The Court also noted how Congress enacted legislation in 1999[47] allowing IPPS hospitals to reclassify from an urban labor market area to a rural one for various reasons. Thus, a geographically urban hospital can be classified as rural, but then redesignate itself back into

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[43] (Bold emphasis added.)
[44] 2021 WL 4502052 (D.D.C. 2021).
[45] *Id.* at *8 (citations omitted).
[46] *Id.* at *2.
[47] 42 U.S.C. § 1395ww(d)(8)(E). *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, § 401, Pub. L. No. 106-113, 113 Stat. 1501 (1999). Since the amendment was made via § 401 of this legislation, a hospital which receives the new rural reclassification is often referred to a "§ 401" hospital.

an urban labor market area for the purposes of fixing its wage index.[48] The Court also noted the separate IPPS payment for a hospital's *capital* costs at 42 U.S.C. § 1395ww(g) (compared to the IPPS payment for *operating* costs), as well as the capital IPPS adjustments found at 42 C.F.R. § 412.320 for large urban hospitals (the capital DSH payment).[49] The Court explained that, following the 2006 rulemaking, a geographically urban hospital which reclassifies as rural under § 401 loses its eligibility for the capital DSH adjustment.[50]

The appellants in *Toledo* were geographically located in an urban labor market area, but applied to the Secretary (and were approved) to reclassify as rural under § 401. The appellants thereafter applied to the MGCRB to reclassify their wage index to an urban labor market area. The appellants' Medicare Contractor later denied their requests for capital DSH adjustments due to their § 401 rural reclassifications. Before the D.C. District Court, the hospitals argued that 42 C.F.R. § 412.320(a)(1)(iii) violated the plain language of the Medicare Act and that it was promulgated in in an arbitrary and capricious manner.[51]

The D.C. District Court rejected the argument that the capital DSH policy in 42 C.F.R. § 412.320(a)(1)(iii) violated the Medicare Act on its face, finding that the Secretary was not prohibited from treating § 401 reclassified hospitals as rural for operating PPS purposes while denying urban status for the purposes of the capital DSH adjustment.[52] The Court next examined, however, whether the Secretary's decision to do so was reasonable. The D.C. District Court made the following findings:

1. "if the Secretary had any policy concerning Section 401 reclassifications before 2006, he never announced such a policy, much less explained the basis for it."[53]

2. The Secretary's decision to not provide a capital DSH adjustment was arbitrary because:

   - "The Secretary has not put forth evidence that the agency took these costs into account, either in 1991, 2000, 2004, or 2006."[54]
   - "[T]he record does not show that the Secretary articulated a consistent policy of treating these reclassified hospitals as rural for capital DSH adjustment purposes, he cannot fall back on any purported general policy of using operating PPS geographic classifications for capital PPS reimbursements."[55]
   - "The Secretary also has not explained, even as a general matter, why classification uniformity outweighs the value of more accurate cost reimbursements. *Cf. Anna Jacques Hosp.*, 797 F.3d at 1161 (upholding Secretary's regulation where the Secretary explained why 'added precision' 'would not justify the added complication') (quotation omitted)."[56]

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[48] *Toledo* at *3.
[49] *Id.* at *3-4.
[50] *Id.* at *4.
[51] *Id.* at *5.
[52] *Id.* at *6-8.
[53] *Id.* at *11.
[54] *Id.*
[55] *Id.*
[56] *Id.*

- "The agency cannot 'entirely fail[ ] to consider' the "relevant data" and the factors that Congress directed it to review. *State Farm*, 63 U.S. at 43. Here, the Secretary did not perform a cost analysis to determine whether reclassified rural hospitals should receive a capital DSH adjustment, nor did he take costs into account at all."[57]

Notwithstanding these findings, the D.C. District Court declined to vacate the regulation at 42 C.F.R. § 412.320(a)(1)(iii) because "vacatur of a rule is not an appropriate remedy on review of an adjudication."[58] Instead, the Court remanded the case to the Medicare Contractor for a redetermination on the appellants' eligibility for a capital DSH adjustment.[59]

Providers' Request for EJR

As background, each of the Providers is an acute care hospital paid by Medicare pursuant to the inpatient and capital prospective payment systems. During the years under appeal, the hospitals were all geographically located in urban areas, operated more than 100 beds, served low-income patients and received § 401 rural reclassifications pursuant to 42 C.F.R. § 412.103.[60]

The Providers are challenging the validity of 42 C.F.R. § 412.320(a)(1)(iii), which states that urban hospitals may qualify for capital DSH payments unless, on or after October 1, 2006, the urban hospital is reclassified as rural. The Providers assert that this regulation is inconsistent with the underlying operating PPS statute, in particular 42 U.S.C. § 1395ww(d)(8)(B), which states that hospitals that have undergone a rural reclassification are rural only for purposes of this subsection 1395ww(d). The capital DSH provisions are found at 42 U.S.C. § 1395ww(g), an entirely different section of the statute, and therefore a rural reclassification under the subsection (d) operating PPS provisions does not apply for subsection (g) capital PPS purposes.[61]

The Providers believe that the promulgation of 42 C.F.R. § 412.320(a)(1)(iii) is, therefore, beyond the authority granted under 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(g), and the regulation must be found invalid.[62] The Providers assert that the Secretary has implicitly acknowledged that he cannot apply rural status for hospitals that have undergone a rural reclassification to payment provisions outside of subsection (d), and provides as an example, that the Secretary has stated with respect to direct graduate medical education ("GME") that no adjustment to the direct GME cap are available for urban hospitals that have reclassified as rural because subsection (d) reclassification "affects only payments under section 1886(d) of the Act . . . [and] payment for direct GME are made under section 1886(h) of the Act."[63] Further, the regulation fails to take into account any variation in cost based on location, as the capital PPS statute permits at 42 U.S.C. § 1395ww(g)(1)(B)(ii).[64]

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[57] *Id.* at *11-12.
[58] *Id.* at *12.
[59] *Id.*
[60] Request for EJR at 7.
[61] *Id.* at 1, 7.
[62] *See id.* at 7-8.
[63] *Id.* at 8 (citing 70 Fed. Reg. 47278, 47437 (Aug. 12, 2005)).
[64] *Id.*

The Providers assert that the Secretary's adoption of the regulation was arbitrary and capricious and violates the Administrative Procedure Act because he failed to establish that the adoption of the exception to the capital DSH adjustment, for providers that reclassified as rural, took into account variations in the relative costs of capital and construction for the different types of facilities or areas in which they are located.[65]

Though 42 C.F.R. § 412.320(a)(1)(iii) has not been vacated, the Providers argue that the merits of their position were adopted by the D.C. District Court in *Toledo*.[66] Further, the Providers contend that the Secretary adopted the FY 2024 hospital IPPS proposed rule in which the Secretary, in response to *Toledo*, proposed to amend 42 C.F.R. § 412.320(a)(1)(iii). Specifically, effective for discharges occurring on or after October 1, 2023, an urban hospital that is reclassified as rural under § 412.103 will no longer be considered rural for purposes of determining capital DSH eligibility. Instead, for purposes of § 412.320, the geographic classifications specified under § 412.64 will apply.[67] However, the Providers explain that for the periods under appeal, CMS and its contractors will continue to apply the 2006 regulation, denying capital DSH to the Providers for this period.[68]

The Providers further contend that since the Board is bound by the regulation being challenged,[69] namely, the validity of 42 C.F.R. § 412.320(a)(1)(iii), it lacks the authority to decide the legal question presented in the Providers' Request for EJR. Since the additional criteria for EJR have also been met, the Providers request the Board grant the request.[70]

Board Decision

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.

1. Jurisdiction – Appropriate Cost Report Claim (FYEs Prior to December 31 ,2016)

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[71] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[72] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does

[65] *Id.* at 8-9.
[66] *Id.* at 9-12.
[67] *Id.* at 9-10 (citing 88 Fed. Reg. 58640, 59117, 59334 (Aug. 28, 2023).
[68] *Id.* at 10-12 (citing 88 Fed. Reg. at 27058-59).
[69] *See* 42 C.F.R. § 405.1867.
[70] Request for EJR at 10-12.
[71] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[72] *Id.* at 70555.

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 Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since all the participants in Case Nos. 23-1210G and 23-1645GC have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

The Providers have appealed from original NPRs or from the failure of the Medicare Contractor to timely issue an NPR.

Based on its review of the record, the Board finds that each of the participants in these group appeals filed their appeals within 180 days of the issuance of their respective final determinations, or within 180 days after the twelve month period in which the Medicare Contractor was to issue a final determination,[73] as required by 42 C.F.R. § 405.1835; that the providers in each case appealed the issue in their respective appeals' and that the Board is not precluded by regulation or statute from reviewing the issue in these appeals. Finally, in each case, 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).

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

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) 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

[73] Medicare Contractors must issue an NPR within twelve months of receiving a Provider's perfected cost report. Providers are afforded the right to appeal if this NPR is not timely received pursuant to 42 C.F.R. § 405.1835(c), which states:

> (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) . . .

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

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.

These regulations are applicable to the cost reporting periods under appeal for all of the participants in these group appeals, which all have cost reporting periods ending on or after December 31, 2016. 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"[74] 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.[75] In these two group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge[76] within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers with FYEs December 31, 2016 or later.

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[77] 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 need not include any findings regarding compliance with the substantive claim requirements and may proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

3. 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 Case Nos. 23-1210G and 23-1645GC are entitled to a hearing before the Board;

2) No question was raised under 42 C.F.R. § 405.1873(a) contesting whether the Providers' cost reports included an appropriate claim for a specific item;

3) Based upon the participants' assertions regarding 42 C.F.R. § 412.320(a)(1)(iii), there are no findings of fact for resolution by the Board;

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[74] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[75] *See* 42 C.F.R. § 405.1873(a).
[76] Board Rule 44.5 states: "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."
[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."

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 question of whether 42 C.F.R. § 412.320(a)(1)(iii), as promulgated in the FY 2007 IPPS Final Rule, is substantively or procedurally valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.320(a)(1)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' EJR Request for the issue and the subject years in Case Nos. 23-1210G and 23-1645GC. 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 this case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

3/27/2024

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Michael Redmond, Novitas Solutions, Inc. (J-L)
Scott Berends, Esq., FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Nina Marsden, Esq.
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RE: ***Request to Correct Provider Information/Dismissal of Untimely-Filed Participant***
Case No. 24-1554G – Hooper Lundy & Bookman FFY 2024 ATRA Unwinding Group
Specifically: St. Anthony's Memorial Hospital (Prov. No. 14-0032)

Dear Ms. Marsden:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned *optional* group in response to your March 11, 2024 "Request for correction to Provider Info." The pertinent facts considered by the Board and the Board's determination are set forth below.

Pertinent Facts:

On **February 23, 2024**, the designated Group Representative, Nina Marsden of Hooper, Lundy & Bookman, P.C. ("Hooper Lundy"), filed an *optional* group appeal request to establish Case No. 24-1554G entitled the "Hooper Lundy & Bookman FFY 2024 ATRA Unwinding Group." The group challenges certain ATRA-required adjustments that it claims should have been unwound in FFY 2024.

Over the course of **February 23, 2024** and **February 24, 2024**, Hooper Lundy then directly added twenty-two (22) participants (i.e., each of these 22 participants filed an appeal request to directly join the *optional* group). Each participant in the group appealed from the FY 2024 IPPS Final Rule published on August 28, 2023 and the deadline to appeal from that final rule was Monday, February 26, 2024.[1] One of the directly-added participants includes Participant No. 16: "St. Anthony's Memorial Hospital 14-0032" ("St. Anthony's Memorial," Prov. No. 14-0032).

On **March 1, 2024**, Hooper Lundy filed notice that the group was fully formed and then also filed a request for expedited judicial review. Significantly, at this time, St. Anthony's Memorial Hospital (Prov. No. 14-0032) remained listed in OH CDMS behind the Participants Tab for this *optional* group as Participant No. 16.

On **March 4, 2024**, Hooper Lundy filed Rule 20 *Certification* that all of the hospital in the group appeal were directly added and "[a]ll of the supporting documentation in OH CDMS is complete

[1] The Providers had 180 days from the date of publication of the final rule. As the 180th day fell on Saturday, February 24, 2024, the filing deadline was extended to the next business day, Monday, February 26, 2024.

and the most accurate information available to the hospitals" and "[t]hosptials do not have any further information to upload." Significantly, at this time, St. Anthony's Memorial Hospital (Prov. No. 14-0032) remained listed in OH CDMS behind the Participants Tab for this *optional* group as Participant No. 16.

On **March 11, 2024**, Hooper Lundy filed a "Request for Correction of Provider Info" wherein it asked the Board to correct the provider information for the participant, St. Anthony's Memorial. According to Hooper Lundy's correspondence, there are two St. Anthony hospital organizations located in Illinois:

- Provider No. 14-0095 which is located in Cook County, Chicago: Saint Anthony Hospital – Cook County (*hereafter, to be referred to as "Saint Anthony - Cook Co."*) and

- Provider No. 14-0032 which is located in Effingham: St. Anthony's Memorial Hospital.

In its March 11th correspondence, Hooper Lundy contends that "[t]his group includes Saint Anthony Hospital (14-0095, Chicago, IL), but *due to a clerical error*, it appears that the provider number was misreported as 14-0032 in the electronic filing in OH CDMS, including in the 'Re:' line of the provider representative's letter."[2] Hooper Lundy also requested that the Board "update in OH CDMS its provider number to 14-0095; its location to Chicago, Cook County, Illinois; and its amount in controversy to $54,660."[3] In support of its request, Hooper Lundy supplied a corrected Provider Representation letter for Saint Anthony - Cook Co. as well an updated Schedule of Providers for purposes of showing the "corrected" estimated amount in controversy for Saint Anthony - Cook Co. Finally, in making this "Correction" request, Hooper Lundy also noted that St. Anthony's Memorial is already included as a participant in a common issue related party ("CIRP") group for the same issue under Case No. 24-1519GC.

The Board further notes that, in its March 11, 2024 letter, Hooper Lundy appears to make a new certification by stating "[o]nce this *correction* ahs been made in OH CDMS, and the revised documentation has been uploaded into OH CDMS, the supporting jurisdictional documentation in OH CDMS in this group is complete and reflects the most accurate information available to the hospitals." In doing so, Hooper Lundy failed to recognize that *it had already made a Rule 20 Certification 7 days earlier on March 4, 2024* and that this statement otherwise implicitly appears to be an attempt to otherwise replace and/or supersede that March 4th Certification without explaining why the Board should allow Hooper Lundy to replace/supersede that Certification.

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the contractor's final determination, the amount in controversy is $10,000 or

[2] (Emphasis added.)
[3] The reimbursement impact reported for the St. Anthony was originally reported as $119,266, which is the same amount included for the provider in the CIRP group, Case No. 24-1519GC.

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.

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing.[4] In this case, the Federal Register was issued on August 28, 2023. The 180th day fell on Saturday, February 24, 2024.[5] In waiting to form this group appeal and then file the direct add requests for the 22 participants on February 23 and 24, 2024 (only several days prior to the filing deadline), Hooper Lundy effectively left no margin for error.

Although Hooper Lundy characterized its March 11, 2024 correspondence as a "Request for Correction to Provider Info", and indicating it is trying to rectify the certain "misreported" provider information that occurred as the result of a typographical error, the Board finds Hooper Lundy's request to be an attempt to *improperly* add a provider to a fully formed group beyond the appeal filing deadline, as it was filed 196 days after the date of the determination and to replace/supersede the Rule 20 Certification it had previously filed on March 4, 2024. ***The Board admonishes Hooper Lundy*** attempting to add the unrelated provider by classifying it as a clerical error when ***all*** of the information and documentation filed for Participant No. 16 "St. Anthony's Memorial Hospital 14-0032" are identified as pertaining to St. Anthony's Memorial (Prov. No. 14-0032) ***and*** *then were certified as being complete* – including but not limited to the participant name enter into OH CDMS, the name listed in the electronic Schedule of Providers for this participant, the amount in controversy documentation for this participant, and the representation letter for this participant.

The Board considered the following facts in making its decision:

- On February 23, 2024, the optional group was established with "St. Anthony's Memorial Hospital 14-0032" listed as Participant No. 16 on the Schedule of Providers for this group in OH CDMS;

- On March 1, 2024, Hooper Lundy designated Case No. 24-1554G to be fully formed where "St. Anthony's Memorial Hospital 14-0032" continued to be listed as Participant No. 16 on the Schedule of Providers for this group in OH CDMS;

- On March 1, 2024, Hooper Lundy filed a request for Expedited Judicial Review ("EJR");[6]

- On March 4, 2024, Hooper Lundy filed its Rule 20 Certification *certifying* that the group (which was one of forty-two groups identified in the exhibit to the letter) was fully populated in OH CDMS with all participants, and that "[a]ll of the supporting

[4] When filing from a Federal Register determination, there is no 5-day mail presumption as the date of publication is considered the receipt date.
[5] Based on the Federal Rules of Procedure, if the last day of the period is a Saturday, Sunday, holiday, or court closure, the period continues to run until the next day that is not a Saturday, Sunday, holiday, or court closure.
[6] Note Board Rule 42.3 specifies that an EJR request "must include the following, to the extent they have not been previously filed: … Confirmation that the group is fully formed in accordance with Rule 19.

documentation in OH CDMS is complete and the most accurate information available to the hospitals" (*i.e.*, it certified that the OH CDMS record for this *optional* group listed all the participants behind the Participants Tab and all jurisdictional documentation is contained in the OH CDMS record for this group).

- On March 7, 2024, Saint Anthony - Cook Co. (Prov. No. 14-0095) signed a Designation of Representative Letter for the ATRA Unwinding issue;

- On March 11, 2024, Hooper Lundy requested the correction of St. Anthony's Memorial (Prov. No. 14-0032) to Saint Anthony - Cook Co. (Prov. No. 14-0095) plus a correction of the amount in controversy and a substitution of the letter of representation.

Contrary to Hooper Lundy's contention, Saint Anthony - Cook Co. (Prov. No. 14-0095) was ***not*** a participant in this *optional* group prior to the February 26, 2024 deadline to appeal from the FY 2024 IPPS Final Rule and prior to certifying that the group was complete.[7] The Board finds there is insufficient evidence in the record for Case No. 24-1554G, that Saint Anthony - Cook Co. was intended to be Participant 16 in this *optional* group rather than St. Anthony's Memorial, because the Direct Add Request, the Provider name and number entered and listed in OH CDMS, the Amount in Controversy documentation, and the Representative Letter all are identified as pertaining to St. Anthony's Memorial (Prov. No. 14-0032). Indeed, Hooper Lundy certified on March 1, 2024 that the group was fully formed and then certified on March 4, 2024 that OH CDMS listed *all of the participants in the group with all of their supporting documentation*. At that point in time of certification, "St. Anthony's Memorial Hospital 14-0032" of Effingham IL was listed as Participant No. 16 in this optional group and was (and still is) listed on the Schedule of Providers as Participant 16 in the group (*not Saint Anthony - Cook Co. (Prov. No. 14-0095))*. *As a result, Hooper Lundy should, at a minimum, have identified any such clerical error* ***prior to making the Rule 20 Certification***.[8] To this end, Rule 20 states:

> ***Prior to*** *certifying that the group is fully formed or the date on which a group is fully formed*, the group representative should review each participating provider's supporting jurisdictional

[7] 42 C.F.R. § 405.1837(e)(1) specifies that "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." Consistent with this regulation, the Board would similarly deny any request to reopen this optional group to allow the addition of Saint Anthony – Cook Co. since the time for that provider to timely file an appeal of the FY 2024 IPPS Final Rule expired on March 26, 2024.

[8] This is not to say that the Board Ruling would have been different had Hooper Lundy identified the clerical error at that point in time. The point is that had Hooper Lundy conducted a ***proper*** Rule 20 Certification process it should have identified the clerical error ***prior to*** making that certification on March 1, 2024. Accordingly, the *alleged* clerical error occurring on February 23, 2024 (the date St. Anthony's Memorial was added to the group) is superseded by the fact that Hooper Lundy subsequently made that March 1, 2024 certification notwithstanding the fact that St. Anthony's Memorial (Prov. No. 14-0095) was 'sand continues to be listed in OH CDMS as a participant in that group on the Schedule of Providers and all of the supporting documents in OH CDMS for that provider are identified as pertaining to St. Anthony's Memorial (Prov. No. 14-0095).

documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS.[9]

Accordingly, ***the Board reminds Hooper Lundy of the importance and meaning of its Rule 20 Certification*** *and encourages Hooper Lundy to "review* ***each*** *participating provider's supporting jurisdictional documentation"* ***prior to*** *certifying that the group is fully formed* ***and*** ***prior to*** *filing a Rule 20 Certification.*

In addition, the Representative Letter for Saint Anthony - Cook Co. was not signed and dated until March 7, 2024, which was well after the time period to file an appeal (which expired on February 26, 2024) based on the August 28, 2023 Federal Register. As a result, the Board finds that Hooper Lundy was not authorized to file an appeal on behalf of Saint Anthony - Cook Co. at the time Case No. 24-1554G was filed, nor when the group was designated to be fully formed.

Based on the above findings, the Board **denies** Hooper Lundy's request to add/correct Saint Anthony - Cook Co. as a participant, to Case No. 24-1554G because it was never a participant in this *optional* group in the first instance and there is no good cause under 42 C.F.R. § 405.1836 to permit the late filing of that direct-add/appeal request. In addition, as noted by Hooper Lundy, the current participant - St. Anthony's Memorial, is already a participant in Case No. 24-1519GC because it is commonly owned by Hospital Sisters Health System ("HSHS"). Therefore, the Board dismisses St. Anthony's Memorial (Prov. No. 14-0032) from the subject *optional* group, Case No. 24-1554G, since it is subject to the mandatory CIRP rules and is required to be a participant in the HSHS CIRP group under Case No. 24-1519GC.

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

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

For the Board:

3/28/2024

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba (J-E) (MAC for 24-1554G)
Pam Van Arsdale, National Government Services, Inc. (J-6) (MAC for 24-1519GC)

[9] (Emphasis in original.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Decision and Notice of Dismissal***
Hooper, Lundy & Bookman, P.C. FFY 2024 ATRA Unwinding Groups
Case Nos. 24-1499GC, *et al*. (*see* Appendix A for listing of 39 group cases)

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced 39 group appeals and the Request for Expedited Judicial Review ("EJR") filed on March 1, 2024. The decision of the Board to deny the Request for EJR and dismiss the appeal for lack of substantive jurisdiction is set forth below.

Issue in Dispute:

The Providers challenge their federal fiscal year ("FY") 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, *as amended* ("TMA"),[1] such that a negative 0.9412 percent adjustment continues past FFY 2023. This negative 0.9412 percent adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FY 2024 IPPS Final Rule.[2]

Statutory and Regulatory Background:

In the federal year FY 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believed that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

[1] As discussed *infra*, the TMA has been amended multiple times.
[2] *E.g.*, PRRB Case 24-1499GC Statement of the Issue at 1 (Feb. 14, 2024).
[3] 72 Fed. Reg. 47130, 47140-47189 (Aug. 22, 2007).
[4] of the Department of Health and Human Services.
[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

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

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

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

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

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[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.
[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.
[12] 82 Fed. Reg. at 38008.

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

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

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

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS Final Rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

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[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.
[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[19] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.

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

A. The Final IPPS Rule for FY 2018

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

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS Final Rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believed that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS Final Rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the

[23] 82 Fed. Reg. at 38009.
[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.

3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS final rule.[27] Finally, the Secretary noted that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

B. The FY 2019 Adjustment to the Standardized Amount

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

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

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believed MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS Final Rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this

[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.
[31] 78 Fed. Reg.at 50515.

adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under ATRA § 631. The Secretary did not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

C. The FY 2020 to FY 2023 Adjustments to the Standardized Amount

In IPPS Final Rules for FYs 2020 through FY 2023, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
>
> ****
>
> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114-255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that

[32] 83 Fed. Reg. at 41157.

> CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[33]

Similar statements were issued for FYs 2021[34] and 2022,[35] and both adopted a +.5 percent adjustment. In the FY 2023 IPPS Final Rule, the Secretary implemented the final, 0.4588 percentage point positive adjustment to the standardized amount and specifically noted that it was a "permanent adjustment" to the rates (*i.e*., that it would carry forward to future years)

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *We stated that this would constitute a* ***permanent*** *adjustment to payment rates*. We also stated that this proposed 0.5 percentage point positive adjustment is the final adjustment prescribed by section 414 of the MACRA. Along with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.
>
> We received no public comments on the proposed adjustment for FY 2023 and are finalizing our proposal to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. As indicated, this finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.[36]

Providers' Request for Hearing:

The Providers frame their appeal as follows:

> The Providers challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced *due to the failure to eliminate the adjustments under*

[33] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).
[34] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).
[35] 86 Fed. Reg. 44774, 44795 (Aug. 13, 2021).
[36] 87 Fed. Reg. 48780, 48800 (Aug. 10 ,2022) (emphasis added).

> *paragraph 7(b)(1)(B) of the TMA* Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, as amended ("TMA"), such that a negative 0.9412% adjustment continues past FFY 2023. This negative 0.9412% adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FFY 2024 IPPS Final Rule.[37]

The Providers claim their FFY 2024 payments are incorrectly low because CMS *did not* ***reverse*** *certain adjustments under the TMA* ***for FFY 2024***.[38] They argue that § 7(b)(4) of the TMA prohibits adjustments made under § 7(b)(1)(B) for a specific year from being included in determining subsequent years' standardized amounts. They claim that certain adjustments have been made under § 7(b)(1)(B)(ii) and (iii) ***but carried forward*** *in violation of § 7(b)(4)*.[39] Specifically, the Providers claim that a positive 0.9412 percent adjustment for FFY 2024 is necessary to eliminate adjustments made under § 7(b)(1)(B) of the TMA.[40]

The Providers recognize that TMA § 7(b)(5) precludes administrative review of adjustment made under TMA § 7(b); however, nevertheless, they argue that there is no preclusion of administrative review over this issue:

> [T]here is no statutory bar to administrative or judicial review of the continued application of an adjustment under section 7(b)(1)(B) of the TMA beyond the FFYs specified in section 7(b)(4) of the TMA. Section 7(b)(5) of the TMA precludes administrative or judicial review of determinations and adjustments made under section 7(b). But it does not preclude review of CMS' continued application of adjustments initially applied under section 7(b)(1)(B) beyond FFY 2023. Rather, the continuation of an adjustment under section 7(b)(1)(B) beyond FFY 2023 is expressly prohibited under sections 7(b)(4) and 7(b)(2) of the TMA. To be clear, this appeal does not challenge the calculation or application of any adjustment for FFY 2010, 2011, 2012, or FFY 2014 and the succeeding fiscal years through FFY 2023. Instead, this appeal challenges the failure to eliminate these adjustments for FFY 2024 such that they continue to be applied in FFY 2024 and subsequent fiscal years. Section 7(b)(5) of Pub. L. 110–90, therefore, does not preclude administrative or judicial review of this appeal, and the PRRB properly has jurisdiction in this appeal.[41]

Providers' Request for Expedited Judicial Review:

The Providers filed a request for Expedited Judicial Review ("EJR") on March 1, 2024. They note that the Board granted EJR in group appeals with the same designated representative for

[37] *E.g.*, PRRB Case 24-1499GC Statement of the Issue at 1 (Feb. 14, 2024).
[38] *Id.* at 2.
[39] *Id.* at 2-3.
[40] *Id.* at 3.
[41] *Id.* at 5.

TMA adjustments and their impact on FFY 2018 and FFY 2019 payments.[42] They also recognize that the Providers in the FFY 2018 group appeals thereafter unsuccessfully sought judicial review in federal court,[43] as discussed in further detail, *infra*.

In its Statement of Issue Under Appeal, the Request for EJR repeats the arguments made in the initial request for hearing.[44] They also argue that the Board has jurisdiction over the group appeals. Each has an amount in controversy of at least $50,000 and they were all timely filed following the publication of IPPS rates in the annual IPPS Final Rule, which constitutes a final determination that may be appealed to the Board under this authority.[45] The Providers also make a brief claim that "there is no statute precluding judicial or Board review of the issues presented[.]"[46] They go on to repeat the same arguments from the initial request for hearing as to why TMA § 7(b)(5) does not preclude Board review of this issue.[47]

Since the Board is required to apply the standardized amounts being challenged, the Providers claim it lacks the authority to decide the questions presented. As a result, and since the Board has jurisdiction over the appeals, the Providers request the Board grant EJR.

Medicare Contractor's Position:

The Medicare Contractor's designated representative, Federal Specialized Services ("FSS"), filed a response to the Request for EJR on March 8, 2024 indicating that it would be filing Jurisdictional Challenges in Cases Nos. 24-1519GC, 24-1554G and 24-1512GC.

In No. Case 24-1554GC, the Medicare Contractor filed an "Initial Jurisdictional Review of Group Appeal" letter which did not note any impediments. However, FSS never filed any Jurisdictional or Substantive Claim challenges in Case No. 24-1554GC.

In Case No. 24-1519GC, the Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter on March 6, 2024 (which was prior to FSS' notification that a challenge would be forthcoming). On March 13, 2024, FSS filed a Jurisdictional Challenge in Case No. 24-1519GC.

Finally, in Case No. 24-1512GC, the Medicare Contractor filed a "Rule 22 Jurisdictional Review" letter on March 7, 2024, as well as a separate notice that a formal Jurisdictional Challenge would be forthcoming. However, FSS never filed a Jurisdictional or Substantive Claim Challenge in Case No. 24-1512GC.

Based on the foregoing, the Board issued a Scheduling Order (pursuant to Board Rule 44.6) for the Providers to file responses to the challenges in Case Nos. 24-1519GC and 24-1512GC. Due to this Scheduling Order, this EJR determination does not address with Case Nos. 24-1519GC and 24-1512GC as the Board has requested additional information from the parties and the 30-day

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[42] Consolidated Request for Expedited Judicial Review at 2 (Mar. 1, 2024) ("Request for EJR").
[43] *Id.* at n.3.
[44] *Id.* at 2-4.
[45] *Id.* at 5 (citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986)).
[46] *Id.*
[47] *Id.* at 5-6 (*accord supra* n.40 and accompanying text).

period for processing the EJR request *in relation to these 2 cases* has not yet begun as previously noticed by the Board to the parties.[48]

No challenges were filed in any of the other *remaining* thirty-nine (39) cases that are the subject of this EJR Determination.

Board's Decision Regarding the EJR Request:

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers are permitted to appeal from a published Federal Register;
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[49]

As noted above, the Medicare Contractor has not filed any jurisdictional challenge or noted any jurisdictional impediments for any providers in any of the thirty-nine (39) appeals that are the subject of this EJR Determination since the receipt of the initial appeals or in its comments relate to the appropriateness of EJR.

The Providers have all appealed from the Federal Register, a valid final determination, within the required timeframe and each case has an amount in controversy that exceeds $50,000. The cases also involve a single interpretation of law that is common to each Provider in each group.

The Board would normally have jurisdiction over this type of issue; however, section 5 of the TMA, however, specifically precludes administrative or judicial review of adjustments made thereunder:

> (5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

[48] In this regard, the Board notes that 42 C.F.R. § 405.1842(b)(2) states: "the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete." See also 42 C.F.R. § 405.1842(c)(3). Here, the Board has not yet established the prerequisite jurisdiction over either of these 2 cases.
[49] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

As noted above, the Providers sought EJR in group appeals using the same designated representative for TMA adjustments and their impact on FFY 2018 and FFY 2019 payments,[50] but were unsuccessful in their pursuit for relief for the FFY 2018 appeals.[51] That prior litigation reinforces that the Board is precluded from reviewing the issue appealed in these cases, and is discussed in further detail, below.

B. D.C. District Court in Fresno Community Hosp. & Med. Ctr. v. Azar[52]

In *Fresno v. Azar*, hundreds of hospitals argued "that an adjustment of at least +1.1588% was required in order for the Secretary not to continue unlawfully a prior -0.7% recoupment adjustment made in fiscal year 2017."[53] The Secretary moved to dismiss the claims in Providers' Complaint, arguing that Congress has prohibited review of the Secretary's determinations and adjustments made under § 7(b) of the TMA.[54] The U.S. District Court for the District of Columbia ("D.C. District Court") agreed with regard to three of five counts, also finding that the claims did not fit within the narrow *ultra vires* exception to Congress' bar on judicial review. Two claims survived the Motion to Dismiss because they pertained to the Secretary's failure to exercise his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I), not adjustments under TMA § 7(b).[55]

The five counts brought by the Providers in *Fresno v. Azar* were as follows:

1. The Secretary's failure to restore the additional -0.7 percent ATRA reduction in 2018 adjustment was unlawful based on the Administrative Procedure Act ("APA"), the Medicare Act, and other statutes;
2. The Secretary violated the APA, the Medicare Act, and other statutes by failing to explain his reasons for not offsetting the additional -0.7 percent recoupment adjustment in 2018 through his "exceptions and adjustments" discretion;
3. The Secretary violated the APA, the Medicare Act, and other statutes by failing to adequately address commenters' questions and requests concerning the use of the Secretary's "exceptions and adjustments" discretion in implementing the 2018 adjustment;
4. The Providers requested that the Court mandamus the Secretary to restore the additional -0.7 percent adjustment which was made in 2017; and
5. Under the All Writs Act, Providers argued that they were entitled to an offsetting positive adjustment of +0.7 percent for fiscal year 2018.[56]

In support of these claims and that they were not precluded from review, the Providers made three arguments. First, that they were not seeking to review the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment into

[50] Request for EJR at 2.
[51] *Id.* at n.3.
[52] 370 F.Supp.3d 139 (D.D.C. 2019) ("*Fresno v. Azar*").
[53] *Id.* at 142.
[54] *Id.*
[55] *Id.* at 143.
[56] *Id.* at 148.

FY 2018. Second, that the court could review the +0.4588 percent positive adjustment and the continuation of the -0.7 percent recoupment adjustment because it was plainly unlawful. Third, and finally, that even if other claims are precluded from review, the claims challenging the Secretary's failure to exercise his "exceptions and adjustments" discretion are not barred by the preclusion statute.

With regard to the first argument that the Providers' challenge was not to the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment, the D.C. District Court disagreed and noted that "crafty pleading" and "clever phrasing" could not avoid the bar on judicial review.[57] It reasoned:

> Plaintiffs' assertion that the Secretary improperly determined that TMA § 7(b)(2) permitted him to continue a -0.7% recoupment adjustment into fiscal year 2018 still challenges a determination or adjustment made under TMA § 7(b). Accordingly, judicial review is barred.
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> ****
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> In order to grant Plaintiffs' requested relief, the Court would need to order the Secretary to make a different adjustment for 2018 than the one that he decided was required. To order the Secretary to make a different adjustment than the one he intended would necessarily require the Court to review an adjustment made under TMA § 7(b), which is prohibited by the preclusion statute. *See* TMA § 7(b)(5). Accordingly, Plaintiffs' claims fall under the clear language of the TMA's preclusion statute.[58]

The Providers also claimed that continuing the -0.7 percent recoupment adjustment into FY 2017 violated TMA § 7(b)(2), which states that an adjustment made under § 7(b)(1)(B) for discharges in a year cannot be included in the determination of standardized amounts for subsequent years. Since the FY 2017 recoupment adjustment was -1.5% instead of -0.8%, the implementation of a +0.4588 adjustment as mandated by Congress fell short when failing to take into account the excess -0.7 percent. Thus, since the adjustment was unlawful, the Providers claimed the preclusion provision did not apply.[59]

The court disagreed, finding that TMA § 7(b)(5) precluded review of *any* determination or adjustment made under § 7(b), not just "proper" ones.[60] More importantly, this argument would completely subsume the *ultra vires* doctrine, which specifically deals with adjustments made "in violation" of a law giving agencies authority:

> Accordingly, Plaintiffs' argument that the Secretary's +0.4588% adjustment violated TMA § 7(b)(2) by leaving in place a recoupment adjustment from 2017 does not overcome the TMA's preclusion

[57] *Id.* at 149.
[58] *Id.* at 150.
[59] *Id.*
[60] *Id.*

> statute. Instead, Plaintiffs' argument should be addressed under the ultra vires doctrine[.][61]

The court then turned to the Providers' second argument, that the continuation of the -0.7% recoupment adjustment was plainly unlawful – or that the Secretary had acted *ultra vires*:

> Even if the preclusion statute applies to Plaintiffs' claims, the Court may still be able to review those claims under the ultra vires doctrine. Congress has not and cannot limit judicial review to correct a patently unlawful agency action. Under the ultra vires doctrine, an agency action is open to judicial review, even in the face of an applicable preclusion statute, when it "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute. [62]

The court acknowledged the Providers' argument: the +0.4588 percent adjustment required by TMA § 7(b)(1)(B)(iii) for fiscal year 2018 was predicated on the 2014 to 2017 recoupment adjustments totaling only -3.2 percent, but there had been an additional -0.7 percent recoupment adjustment in 2017. The FY 2018 +0.4588 percent adjustment did not "remove" the FY 2017 -0.7 percent recoupment adjustment, which violated TMA § 7(b)(2) by allowing adjustments from prior years to be included in adjustments for subsequent years. Since the adjustment violates TMA § 7(b)(2), it is "plainly unlawful" or *ultra vires* and subject to judicial review, despite the preclusion provision at TMA § 7(b)(5).[63]

The court disagreed, noting that TMA § 7(b)(1)(B)(iii) *explicitly* required the Secretary to make the +0.4588 percent adjustment, and *only* that adjustment, for FY 2018. It also explained that this very specific mandate was enacted later in time than the general prohibition on continuing recoupment adjustments found in TMA § 7(b)(2). The court concluded:

> The Secretary's decision to follow the explicit Congressional mandate to implement a +0.4588% adjustment and "not make the adjustment . . . that would otherwise apply" in 2018, which Congress passed with full knowledge of the greater-than-previously-estimated 2017 recoupment adjustment, was not an ultra vires act.[64]

Thus, the court found that the preclusion of administrative or judicial review applied to counts 1, 4, and 5 of the Providers' Complaint. Counts 2 and 3, however, concerned whether the "Secretary failed to adequately explain the rationale for[, and failing to address commenters' questions and requests regarding,] not applying his 'exceptions and adjustments' discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7% adjustment in 2018, offsetting the 2017 -0.7% recoupment adjustment."[65] The court noted it could not review a claim that was "inextricably

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[61] *Id.* at 152.
[62] *Id.* (citations omitted).
[63] *Id.* at 153.
[64] *Id.*
[65] *Id.* at 156-157.

intertwined" with barred claims.[66] The Secretary argued that he did not use his "exceptions and adjustments" discretion because he determined a +0.7 percent adjustment was prohibited under TMA § 7(b)(1)(B)(iii).[67] The court found, however:

> It is not clear from the 2018 final rule, or from any other source provided by Defendant, that the Secretary considered whether or not to grant a +0.7% adjustment under the "exceptions and adjustments" discretionary authority, despite comments urging him to do so.[68]

The court acknowledged that perhaps the Secretary declined to exercise his discretionary authority because he considered it to be prohibited under the TMA, thus making Counts 2 and 3 "inextricably intertwined" with the other, precluded claims. The court found, however, that the Secretary failed to prove that and, as a result, it had jurisdiction over these two, specific claims.[69]

C. D.C. Circuit Court in Fresno Community Hosp. & Med. Ctr. v. Azar[70]

The Providers appealed to the U.S. Circuit Court for the District of Columbia ("D.C. Circuit Court"). It found that TMA § 7(b)(5) defeats the presumption favoring review of agency action, so the only question was whether the challenged action was "the sort shielded form review."[71] It made the same finding as the D.C. District Court: that labeling the challenge as a continued inclusion or failure to reverse a -0.7 percent adjustment is still, in reality, a challenge to an "adjustment" which is barred by TMA § 7(b)(5).[72]

The court next considered the Providers' argument that the -0.6 percent adjustment should be set aside as *ultra vires*, noting that they had the burden of showing "that the Secretary flouted a clear, specific, statutory command."[73] The Providers made the same argument as before the D.C. District Court: that TMA § 7(b)(2) bars the Secretary from allowing any recoupment adjustment to continue into a subsequent year, and by carrying over the -0.7% adjustment into 2018, the Secretary violated an explicit statutory prohibition.[74] The D.C. Circuit Court disagreed, noting that the Providers did not object to *other* adjustments being carried over in prior fiscal years. Ultimately, the court found that TMA § 7(b)(2) did not actually forbid the Secretary from carrying over adjustments and affirmed the D.C. District Court's decision.

D. Expedited Judicial Review

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

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[66] *Id.* at 157.
[67] *Id.*
[68] *Id.* at 158.
[69] *Id.*
[70] 987 F.3d 158 (D.C. Cir. 2021) ("*Fresno v. Cochran*").
[71] *Id.* at 161 (quoting *Amgen Inc. v. Smith*, 357 F.3d 103, 113 (D.C. Cir. 2004).
[72] *Id.* at 161-162.
[73] *Id.* at 162 (citing *Nyunt v. Chairman, Broad Bd. Of Govs*., 589 F.3d, 449 (D.C. Cir. 2009)).
[74] *Id.*

to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

E. Preclusion of Board Jurisdiction

As noted above and in the decision of both the D.C. District Court and the D.C. Circuit Court in *Fresno v. Azar*, TMA § 7(b)(5) generally prohibits administrative and judicial review of any determinations or adjustments made pursuant to the TMA. The Providers in these appeals "challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the ***failure to eliminate*** *the adjustments under paragraph 7(b)(1)(B) of the TMA*. . . ."[75] They also claim that TMA § 7(b)(5) "does not preclude review of CMS' ***continued application*** *of adjustments initially applied* under section 7(b)(1)(B) ***beyond FFY 2023***."[76]

The D.C. District Court directly addressed these arguments and found that the distinction between challenging an adjustment and challenging the failure to eliminate an adjustment amounts to nothing more than "crafty pleading" and "clever phrasing" that cannot avoid the bar on judicial review.[77] In this regard, the Board further notes that, in the preamble to the FY 2024 IPPS Final Rule, the Secretary responded to directly to the issue raised in this appeal and *relied on the TMA*, as amended, in declining "to adjust any payments in FY 2024 [*sic* to] restore any additional amount of the original 3.9 percentage point reduction."[78] Indeed, the *permanence* of the adjustment made in

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[75] *E.g.*, PRRB Case 24-1499GC Statement of the Issue at 1 (Feb. 14, 2024) (emphasis added).
[76] *Id.* at 5.
[77] *Fresno v. Azar* at 149.
[78] 88 Fed. Reg. at 58654. The following is an excerpt from this preamble discussion in the FY 2024 IPPS Final Rule at 88 Fed. Reg. 58654 to give the context for the quote:

> *Comment*: Several commenters requested that CMS make a positive adjustment to restore the full amount of the documentation and coding recoupment adjustments in the FY 2024 IPPS final rule which they asserted is required under section (7)(B)(2) and (4) of the TMA . . ., Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 (Pub. L. 110–90). Commenters stated that the statute is explicit that CMS may not carry forward any documentation and coding adjustments applied in fiscal years 2010 through 2017 into IPPS rates after FY 2023. Commenters contended that CMS, by its own admission, has restored only 2.9588 percentage points of a total 3.9 percentage point reduction. By not fully restoring the total reductions, commenters believe that CMS is improperly extending payment adjustments beyond the FY 2023 statutory limit. A commenter stated that, even if CMS disputes it is required to make such an adjustment, CMS should use its special exceptions and adjustments authority to address the shortfall.
> *Response*: As of FY 2023, CMS completed the statutory requirements of section 7(b)(1)(B) of Pub. L. 110–90 as amended . . . . As we discussed in the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 through 44795), the FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 through 58445) and in prior rules, we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act **to adjust payments in FY 2024 restore any additional amount of the original 3.9 percentage point reduction, given Congress' directive regarding prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act**. Accordingly, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38009), we implemented the required +0.4588 percentage point adjustment to the standardized

the FY 2023 IPPS Final Rule was specifically discussed as part of that rulemaking as noted by the Secertary in the preamble to the FY 2023 IPPS Final Rule: "We stated [in the proposed rulemaking] that this would constitute a *permanent* adjustment to payment rates."[79] Accordingly, the Board finds that the Board jurisdiction over this appeal is precluded by TMA § 7(b)(5).

The only claims which survived in *Fresno v. Azar* were those alleging the Secretary should have applied his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7 percent adjustment in 2018. The Providers in these group appeals have not cited 42 U.S.C. § 1395ww(d)(5)(I) or discussed the Secretary's "exceptions and adjustments" discretion in any capacity. Board Rule 7.2.1 (Nov. 2021) requires that, for each issue raised in an appeal request, a Provider must submit a concise issue statement describing, *inter alia*, the controlling authority, why the adjustment is incorrect, and the basis for jurisdiction before the Board. The Providers failed to make this argument in their requests for hearing or Request for EJR and, as such, the Board will not address or consider it as part of the appeal.

Based on the foregoing, the Board finds that, pursuant to TMA § 7(b)(5), it lacks substantive jurisdiction to review the issue appealed in the thirty-nine (39) group appeals listed in **Appendix A** and, therefore, is dismissing the cases and denying their respective Requests for EJR for the same reason.[80]

> amount for FY 2018. In the FY 2019 IPPS/LTCH PPS final rule (FY 2019 final rule) (83 FR 41157), the FY 2020 IPPS/LTCH PPS final rule (FY 2020 final rule) (84 FR 42057), the FY 2021 IPPS/LTCH PPS final rule (FY 2021 final rule) (85 FR 58444 and 58445), the FY 2022 IPPS/LTCH PPS final rule (FY 2022 final rule) (86 FR 44794 and 44795), and the FY 2023 IPPS/LTCH PPS final rule (FY 2023 final rule) (87 FR 48800), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, FY 2022 and FY 2023, respectively. As discussed in the FY 2023 final rule, the finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.

(Italics emphasis in original and bold and italics emphasis added.)

[79] 87 Fed. Reg. at 48800 (emphasis added). Similarly, the Board notes that the FY 2023 IPPS Proposed Rule included the following discussion in the preamble at 87 Fed. Reg. 28108, 28126 (May 10, 2022) (emphasis added):

> In the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), the FY 2020 IPPS/ LTCH PPS final rule (84 FR 42057), FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 and 58445), and the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 and 44795), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, and FY 2022, respectively. *We indicated the FY 2018, FY 2019, FY 2020, FY 2021, and FY 2022 adjustments were* ***permanent*** *adjustments to payment rates*. We also stated that we plan to propose a future adjustment required under section 414 of the MACRA for FY 2023 in future rulemaking.
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> ****
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> Consistent with the requirements of section 414 of the MACRA, we are proposing to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *This would constitute a* ***permanent*** *adjustment to payment rates*.

[80] The Board recognizes that the Providers maintain the Board should find jurisdiction over the instant appeals "consistent with the Board's previous grans of EJR" for the cases underlying the *Fresno v. Azar* litigation. However, those prior determination did not address the TMA preclusion provisions, and it is clear that both the D.C. District Court and the D.C. Circuit Court specifically found that the TMA preclusion provisions were applicable to those appeals. Consequently, the Board finds that it erred in finding jurisdiction in those earlier cases as supported by the analysis in this determination and the Courts' decisions in the *Fresno v. Azar* litigation.

Accordingly, the Board closes these 39 groups and removes them from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

For the Board:

3/28/2024

X Clayton J. Nix

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

Enclosure: Appendix A – List of 39 Group Cases Covered by this Dismissal Determination

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Byron Lamprecht – WPS Government Health Administrators (J-5)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Michael Redmond, Novitas Solutions, Inc. (J-L) (J-H)
Danelle Decker, National Government Services, Inc. (J-K)
John Bloom, Noridian Healthcare Solutions (J-F)
Geoff Pike, First Coast Service Options, Inc. (J-N)
Pamela VanArsdale, National Government Services, Inc. (J-6)
Wilson Leong, FSS

Appendix A
List of 39 Cases Covered by this Dismissal Determination[81]

1. **24-1499GC** Keck Medicine of USC FFY 2024 ATRA Unwinding CIRP Group
2. **24-1500GC** Cedars-Sinai Health FFY 2024 ATRA Unwinding CIRP Group
3. **24-1501GC** AHMC Healthcare FFY 2024 ATRA Unwinding CIRP Group
4. **24-1502GC** Scripps Health FFY 2024 ATRA Unwinding CIRP Group
5. **24-1505GC** MemorialCare FFY 2024 ATRA Unwinding CIRP Group
6. **24-1506GC** Northern Light Health FFY 2024 ATRA Unwinding CIRP Group
7. **24-1507GC** Resilience Healthcare FFY 2024 ATRA Unwinding CIRP Group
8. **24-1508GC** Sinai Health FFY 2024 ATRA Unwinding CIRP Group
9. **24-1509GC** Thorek Health System FFY 2024 ATRA Unwinding CIRP Group
10. **24-1510GC** Mass General Brigham FFY 2024 ATRA Unwinding CIRP Group
11. **24-1511GC** Adventist Health FFY 2024 ATRA Unwinding CIRP Group
12. **24-1513GC** Halifax Hospital Medical FFY 2024 ATRA Unwinding CIRP Group
13. **24-1514GC** Beth Israel Lahey Health FFY 2024 ATRA Unwinding CIRP Group
14. **24-1515GC** St. Luke's FFY 2024 ATRA Unwinding CIRP Group
15. **24-1516GC** Prospect Medical Holdings FFY 2024 ATRA Unwinding CIRP Group
16. **24-1517GC** Lee Memorial FFY 2024 ATRA Unwinding CIRP Group
17. **24-1518GC** Stanford Health Care FFY 2024 ATRA Unwinding CIRP Group
18. **24-1520GC** Renown Health FFY 2024 ATRA Unwinding CIRP Group
19. **24-1521GC** UPMC FFY 2024 ATRA Unwinding CIRP Group
20. **24-1522GC** Cottage Health FFY 2024 ATRA Unwinding CIRP Group
21. **24-1523GC** UHS FFY 2024 ATRA Unwinding CIRP Group
22. **24-1524GC** Providence Health FFY 2024 ATRA Unwinding CIRP Group
23. **24-1525GC** University of Chicago MC FFY 2024 ATRA Unwinding CIRP Group
24. **24-1527GC** PIH Health FFY 2024 ATRA Unwinding CIRP Group
25. **24-1528GC** LifePoint Health FFY 2024 ATRA Unwinding CIRP Group
26. **24-1530GC** Sharp Healthcare FFY 2024 ATRA Unwinding CIRP Group
27. **24-1532GC** HCA FFY 2024 ATRA Unwinding CIRP Group
28. **24-1533GC** Hackensack Meridian FFY 2024 ATRA Unwinding CIRP Group
29. **24-1534GC** Emanate Health FFY 2024 ATRA Unwinding CIRP Group
30. **24-1535GC** UNC Health FFY 2024 ATRA Unwinding CIRP Group
31. **24-1536GC** Kaiser Health FFY 2024 ATRA Unwinding CIRP Group
32. **24-1537GC** CommonSpirit Health FFY 2024 ATRA Unwinding CIRP Group
33. **24-1538GC** Concord Hospital FFY 2024 ATRA Unwinding CIRP Group
34. **24-1539GC** College Health FFY 2024 ATRA Unwinding CIRP Group
35. **24-1541GC** Presbyterian Healthcare FFY 2024 ATRA Unwinding CIRP Group
36. **24-1544GC** CHS FFY 2024 ATRA Unwinding CIRP Group
37. **24-1545GC** Pipeline FFY 2024 ATRA Unwinding CIRP Group
38. **24-1547GC** John Muir Health FFY 2024 ATRA Unwinding CIRP Group
39. **24-1554G** Hooper Lundy & Bookman FFY 2024 ATRA Unwinding Group

[81] The Providers' Request for EJR also encompassed Cases 24-1519GC and 24-1512GC but, as outlined herein, the Board has issued a Scheduling Order for the Providers to respond to Jurisdictional Challenges in those two cases. The instant EJR Determination does not encompass Cases 24-1519GC and 24-1512GC, which will be addressed under separate cover. *See supra note* 48 and accompanying text.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Nina Marsden, Esq.
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RE: ***EJR Decision and Notice of Dismissal***
Community Med Ctrs FFY 2024 ATRA Unwinding CIRP Group
Case No. 24-1503GC

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board") has reviewed the records in the above-referenced common issue related party ("CIRP") group appeal and the Request for Expedited Judicial Review ("EJR") filed on March 1, 2024. The decision of the Board to deny the Request for EJR and dismiss the appeal for lack of substantive jurisdiction is set forth below.

Issue in Dispute:

The Providers challenge their federal fiscal year ("FY") 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, *as amended* ("TMA"),[1] such that a negative 0.9412 percent adjustment continues past FY 2023. This negative 0.9412 percent adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FY 2024 IPPS Final Rule.[2]

Statutory and Regulatory Background:

In the FY 2008 inpatient prospective payment system ("IPPS") final rule,[3] the Secretary[4] adopted the Medicare severity diagnosis-related group ("MS–DRG") patient classification system for the IPPS, effective October 1, 2007, to better recognize severity of illness in Medicare payment rates for acute care hospitals. The adoption of the MS–DRG system resulted in the expansion of the number of DRGs from 538 in FY 2007 to 745 in FY 2008. The Secretary believed that, by increasing the number of MS–DRGs and more fully taking into account patient severity of illness in Medicare payment rates for acute care hospitals, MS–DRGs would encourage hospitals to improve their documentation and coding of patient diagnoses.[5]

[1] As discussed *infra*, the TMA has been amended multiple times.
[2] Statement of the Issue at 1 (Feb. 23, 2024).
[3] 72 Fed. Reg. 47130, 47140-47189 (Aug. 22, 2007).
[4] of the Department of Health and Human Services.
[5] 81 Fed. Reg. 56762, 56780 (Aug. 22, 2016).

In the FY 2008 IPPS final rule, the Secretary indicated that the adoption of the MS–DRGs had the potential to lead to increases in aggregate payments without a corresponding increase in actual patient severity of illness due to the incentives for additional documentation and coding. In that final rule, the Secretary exercised the authority under section 42 U.S.C. § 1395ww(d)(3)(A)(vi), which authorizes the Secretary to maintain budget neutrality by adjusting the national standardized amount, to eliminate the estimated effect of changes in coding or classification that do not reflect real changes in case-mix. CMS actuaries estimated that maintaining budget neutrality required an adjustment of -4.8 percent to the national standardized amount. The Secretary provided for phasing in this -4.8 percent adjustment over 3 years. Specifically, the Secretary established prospective documentation and coding adjustments of -1.2 percent for FY 2008, -1.8 percent for FY 2009, and -1.8 percent for FY 2010.[6]

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

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

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

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

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[6] *See* 82 Fed. Reg. 37990, 38008 (Aug. 17, 2017).
[7] Pub. L. 110–90, 121 Stat. 984 (2007).
[8] *Id.* at 986.
[9] *See* 82 Fed. Reg. at 38008.
[10] Pub. L. 112-240, 126 Stat. 2313 (2013).
[11] *Id.* at 2353.
[12] 82 Fed. Reg. at 38008.

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

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

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

In the FY 2017 IPPS/LTCH PPS proposed rule,[20] due to lower than previously estimated inpatient spending, the Secretary determined that an adjustment of -0.8 percentage point in FY 2017 would not recoup the $11 billion under ATRA § 631. For the FY 2017 IPPS/LTCH PPS Final Rule,[21] the Secretary's actuaries estimated that, to the nearest tenth of a percentage point, the FY 2017 documentation and coding adjustment factor that would recoup as closely as possible $11 billion from FY 2014 through FY 2017 without exceeding this amount is -1.5 percentage points. Based on those updated estimates by the Office of the Actuary, the Secretary made a -1.5 percentage point adjustment for FY 2017 as the final adjustment required under ATRA § 631.[22]

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[13] Pub. L. 114–10, § 414, 129 Stat. 87, 162-163 (2015).
[14] Pub. L. 114–255, 130 Stat. 1033 (2016).
[15] *Id.* at 1319-1320. *See also* 82 Fed. Reg. at 38008.
[16] 82 Fed. Reg. at 38008.
[17] *Id.*
[18] 79 Fed. Reg. 49853, 49874 (Aug. 22, 2014).
[19] 80 Fed. Reg. 49326, 49345 (Aug. 17, 2015).
[20] 81 Fed. Reg. 24946, 24966 (Apr. 27, 2016)
[21] 81 Fed. Reg. 56761 (Aug. 22, 2016).
[22] *Id.* at 56785.

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

A. The Final IPPS Rule for FY 2018

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

The Secretary responded by stating that, as discussed in the FY 2017 IPPS/LTCH PPS Final Rule,[25] CMS had completed the $11 billion recoupment required under ATRA § 631. The Secretary also continued to disagree with commenters who asserted that MACRA § 414 was intended to augment or limit the separate obligation under the ATRA to fully offset $11 billion by FY 2017.[26] Moreover, the Secretary pointed out in the FY 2018 IPPS/LTCH PPS proposed rule, he believed that the directive regarding the applicable adjustment for FY 2018 is clear. While the Secretary had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 requires that he not make the single positive adjustment he intended to make in FY 2018 but instead make a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023. The Secretary pointed out that, as noted by the commenters and discussed in the FY 2017 IPPS/LTCH PPS Final Rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage point adjustment originally estimated in the FY 2014 IPPS/LTCH PPS

[23] 82 Fed. Reg. at 38009.
[24] *Id.*
[25] 81 Fed. Reg. 56783-85.
[26] *Id.* at 56784.

final rule.[27] Finally, the Secretary noted that 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and that this change was enacted on December 13, 2016, ***after*** CMS had proposed and finalized the -1.5 percentage point adjustment as the final adjustment required under ATRA § 631 in the FY 2017 rulemaking. The Secretary finalized the +0.4588 percentage point adjustment to the standardized amount for FY 2018, as required under 21-CCA § 15005.[28]

B. The FY 2019 Adjustment to the Standardized Amount

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

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

The Secretary responded by stating that, as discussed in the FY 2019 IPPS/LTCH PPS proposed rule, he believed MACRA § 414 and 21-CCA § 15005 clearly set forth the levels of positive adjustments for FYs 2018 through 2023. He was not convinced that the adjustments prescribed by MACRA were predicated on a specific ''baseline'' adjustment level. While he had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under ATRA § 631, MACRA § 414 required that a 0.5 percentage point positive adjustment be implemented for each of FYs 2018 through 2023, rather than the single positive adjustment he had anticipated making in FY 2018. As discussed in the FY 2017 IPPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, MACRA § 414 would not fully restore even the 3.2 percentage points adjustment originally estimated in the FY 2014 IPPS final rule.[31] Moreover, as discussed in the FY 2018 IPPS Final Rule, 21-CCA § 15005 further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point and this adjustment was enacted on December 13, 2016, ***after*** the Secretary had proposed and finalized the final negative -1.5 percentage points adjustment required under

[27] 78 Fed. Reg. 50496, 50515 (Aug. 19, 2013).
[28] 82 Fed. Reg. at 38009.
[29] 83 Fed. Reg. 41144 (Aug. 17, 2018).
[30] *Id.* at 41157.
[31] 78 Fed. Reg.at 50515.

ATRA § 631. The Secretary did not believe that Congress enacted these adjustments with the intent that there would be an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017.[32]

C. The FY 2020 to FY 2023 Adjustments to the Standardized Amount

In IPPS Final Rules for FYs 2020 through FY 2023, the Secretary adopted only a +.5 percent adjustment. In this regard, the Secretary stated the following in the preamble to the FY 2020 IPPS Final Rule:

> In the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171) consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2020. We indicated that this would constitute a permanent adjustment to payment rates. We stated in the proposed rule that we plan to propose future adjustments required under section 414 of the MACRA for FYs 2021 through 2023 in future rulemaking.
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> ****
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> As we discussed in the FY 2020 IPPS/LTCH PPS proposed rule (84 FR 19170 through 19171), and in response to similar comments in the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. While we had anticipated making a positive adjustment in FY 2018 to offset the reductions required to recoup the $11 billion under section 631 of the ATRA, section 414 of the MACRA required that we implement a 0.5 percentage point positive adjustment for each of FYs 2018 through 2023, and not the single positive adjustment we intended to make in FY 2018. As discussed in the FY 2017 IPPS/LTCH PPS final rule, by phasing in a total positive adjustment of only 3.0 percentage points, section 414 of the MACRA would not fully restore even the 3.2 percentage point adjustment originally estimated by CMS in the FY 2014 IPPS/LTCH PPS final rule (78 FR 50515). Moreover, as discussed in the FY 2018 IPPS/LTCH PPS final rule, Public Law 114-255, which further reduced the positive adjustment required for FY 2018 from 0.5 percentage point to 0.4588 percentage point, was enacted on December 13, 2016, after CMS had proposed and finalized the final negative -1.5 percentage point adjustment required under section 631 of the ATRA. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the

[32] 83 Fed. Reg. at 41157.

> higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to adjust payments in FY 2020 to restore any additional amount of the original 3.9 percentage point reduction, given Congress' prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act.
>
> After consideration of the public comments we received, we are finalizing our proposal to implement a 0.5 percentage point adjustment to the standardized amount for FY 2020.[33]

Similar statements were issued for FYs 2021[34] and 2022,[35] and both adopted a +.5 percent adjustment. In the FY 2023 IPPS Final Rule, the Secretary implemented the final, 0.4588 percentage point positive adjustment to the standardized amount and specifically noted that it was a "permanent adjustment" to the rates (*i.e*., that it would carry forward to future years):

> Consistent with the requirements of section 414 of the MACRA, we proposed to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *We stated that this would constitute a* ***permanent*** *adjustment to payment rates*. We also stated that this proposed 0.5 percentage point positive adjustment is the final adjustment prescribed by section 414 of the MACRA. Along with the 0.4588 percentage point positive adjustment for FY 2018, and the 0.5 percentage point positive adjustments for FY 2019, FY 2020, FY 2021, and FY 2022, this final adjustment will result in combined positive adjustment of 2.9588 percentage points (or the sum of the adjustments for FYs 2018 through 2023) to the standardized amount.
>
> We received no public comments on the proposed adjustment for FY 2023 and are finalizing our proposal to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. As indicated, this finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.[36]

Providers' Request for Hearing:

The Providers frame their appeal as follows:

> The Providers challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly

[33] 84 Fed. Reg. 42044, 42057 (Aug. 16, 2019).
[34] 85 Fed. Reg. 58432, 58444-45 (Sept. 18, 2020).
[35] 86 Fed. Reg. 44774, 44795 (Aug. 13, 2021).
[36] 87 Fed. Reg. 48780, 48800 (Aug. 10 ,2022) (emphasis added).

> reduced *due to the failure to eliminate the adjustments under paragraph 7(b)(1)(B) of the TMA* Abstinence Education, and QI Programs Extension Act of 2007, Pub. L. No. 110–90, 121 Stat. 984, 986-87, as amended ("TMA"), such that a negative 0.9412% adjustment continues past FFY 2023. This negative 0.9412% adjustment to IPPS rates is the net result of all adjustments under section 7(b)(1)(B) of the TMA that were continued rather than eliminated in the FFY 2024 IPPS Final Rule.[37]

The Providers claim their FFY 2024 payments are incorrectly low *because CMS did not **reverse** certain adjustments under the TMA **for FFY 2024***.[38] They argue that § 7(b)(4) of the TMA prohibits adjustments made under § 7(b)(1)(B) for a specific year from being included in determining subsequent years' standardized amounts. They claim that certain adjustments have been made under § 7(b)(1)(B)(ii) and (iii) ***but carried forward** in violation of § 7(b)(4)*.[39] Specifically, the Providers claim that a positive 0.9412 percent adjustment for FFY 2024 is necessary to eliminate adjustments made under § 7(b)(1)(B) of the TMA.[40]

The Providers recognize that TMA § 7(b)(5) precludes administrative review of adjustment made under TMA § 7(b); however, nevertheless, they argue that there is no preclusion of administrative review over this issue:

> [T]here is no statutory bar to administrative or judicial review of the continued application of an adjustment under section 7(b)(1)(B) of the TMA beyond the FFYs specified in section 7(b)(4) of the TMA. Section 7(b)(5) of the TMA precludes administrative or judicial review of determinations and adjustments made under section 7(b). But it does not preclude review of CMS' continued application of adjustments initially applied under section 7(b)(1)(B) beyond FFY 2023. Rather, the continuation of an adjustment under section 7(b)(1)(B) beyond FFY 2023 is expressly prohibited under sections 7(b)(4) and 7(b)(2) of the TMA. To be clear, this appeal does not challenge the calculation or application of any adjustment for FFY 2010, 2011, 2012, or FFY 2014 and the succeeding fiscal years through FFY 2023. Instead, this appeal challenges the failure to eliminate these adjustments for FFY 2024 such that they continue to be applied in FFY 2024 and subsequent fiscal years. Section 7(b)(5) of Pub. L. 110–90, therefore, does not preclude administrative or judicial review of this appeal, and the PRRB properly has jurisdiction in this appeal.[41]

Providers' Request for Expedited Judicial Review:

The Providers filed a request for Expedited Judicial Review ("EJR") on March 1, 2024. They note that the Board granted EJR in group appeals with the same designated representative for

[37] Statement of the Issue at 1 (Feb. 23, 2024) (emphasis added).
[38] *Id.* at 2.
[39] *Id.* at 2-3.
[40] *Id.* at 3.
[41] *Id.* at 5.

TMA adjustments and their impact on FFY 2018 and FFY 2019 payments.[42] They also recognize that the Providers in the FFY 2018 group appeals thereafter unsuccessfully sought judicial review in federal court,[43] as discussed in further detail, *infra*.

In its Statement of Issue Under Appeal, the Request for EJR repeats the arguments made in the initial request for hearing.[44] They also argue that the Board has jurisdiction over the group appeals. Each has an amount in controversy of at least $50,000 and they were all timely filed following the publication of IPPS rates in the annual IPPS Final Rule, which constitutes a final determination that may be appealed to the Board under this authority.[45] The Providers also make a brief claim that "there is no statute precluding judicial or Board review of the issues presented[.]"[46] They go on to repeat the same arguments from the initial request for hearing as to why TMA § 7(b)(5) does not preclude Board review of this issue.[47]

Since the Board is required to apply the standardized amounts being challenged, the Providers claim it lacks the authority to decide the questions presented. As a result, and since the Board has jurisdiction over the appeals, the Providers request the Board grant EJR.

Medicare Contractor's Position:

The Medicare Contractor filed a response to the Request for EJR on March 1, 2024 and notes that it is ***not*** filing any jurisdictional challenges. It also stated that the appeal and Request for EJR were filed in advance of the cost report deadline, so it is impossible to determine if a substantive claim challenge is appropriate.

Board's Decision Regarding the EJR Request:

A. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers are permitted to appeal from a published Federal Register;
- The matter at issue involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[48]

[42] Request for Expedited Judicial Review at 2 (Mar. 1, 2024) ("Request for EJR").
[43] *Id.* at n.3.
[44] *Id.* at 2-4.
[45] *Id.* at 5 (citing *Wash. Hosp. Ctr. v. Bowen*, 795 F.2d 139, 146 (D.C. Cir. 1986)).
[46] *Id.*
[47] *Id.* at 5-6 (*accord supra* n.40 and accompanying text).
[48] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

As noted above, the Medicare Contractor has not filed any jurisdictional challenge or noted any jurisdictional impediments for any providers since the receipt of the initial appeals or in its comments related to the appropriateness of EJR.

The Providers have all appealed from the Federal Register, a valid final determination, within the required timeframe and each case has an amount in controversy that exceeds $50,000. The cases also involve a single interpretation of law that is common to each Provider in each group.

The Board would normally have jurisdiction over this type issue; however, section 5 of the TMA specifically precludes administrative or judicial review of adjustments made thereunder:

> (5) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1878 of the Social Security Act (42 U.S.C. 1395oo) or otherwise of any determination or adjustments made under this subsection.

As noted above, the Providers sought EJR in group appeals using the same designated representative for TMA adjustments and their impact on FFY 2018 and FFY 2019 payments,[49] but were unsuccessful in their pursuit for relief for the FFY 2018 appeals.[50] That prior litigation reinforces that the Board is precluded from reviewing the issue appealed in these cases, and is discussed in further detail, below.

B. D.C. District Court in Fresno Community Hosp. & Med. Ctr. v. Azar[51]

In *Fresno v. Azar*, hundreds of hospitals argued "that an adjustment of at least +1.1588% was required in order for the Secretary not to continue unlawfully a prior -0.7% recoupment adjustment made in fiscal year 2017."[52] The Secretary moved to dismiss the claims in Providers' Complaint, arguing that Congress has prohibited review of the Secretary's determinations and adjustments made under § 7(b) of the TMA.[53] The U.S. District Court for the District of Columbia ("D.C. District Court") agreed with regard to three of five counts, also finding that the claims did not fit within the narrow *ultra vires* exception to Congress' bar on judicial review. Two claims survived the Motion to Dismiss because they pertained to the Secretary's failure to exercise his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I), not adjustments under TMA § 7(b).[54]

The five counts brought by the Providers in *Fresno v. Azar* were as follows:

1. The Secretary's failure to restore the additional -0.7 percent ATRA reduction in 2018 adjustment was unlawful based on the Administrative Procedure Act ("APA"), the Medicare Act, and other statutes;

[49] Request for EJR at 2.
[50] *Id.* at n.3.
[51] 370 F.Supp.3d 139 (D.D.C. 2019) ("*Fresno v. Azar*").
[52] *Id.* at 142.
[53] *Id.*
[54] *Id.* at 143.

2. The Secretary violated the APA, the Medicare Act, and other statutes by failing to explain his reasons for not offsetting the additional -0.7 percent recoupment adjustment in 2018 through his "exceptions and adjustments" discretion;
3. The Secretary violated the APA, the Medicare Act, and other statutes by failing to adequately address commenters' questions and requests concerning the use of the Secretary's "exceptions and adjustments" discretion in implementing the 2018 adjustment;
4. The Providers requested that the Court mandamus the Secretary to restore the additional -0.7 percent adjustment which was made in 2017; and
5. Under the All Writs Act, Providers argued that they were entitled to an offsetting positive adjustment of +0.7 percent for fiscal year 2018.[55]

In support of these claims and that they were not precluded from review, the Providers made three arguments. First, that they were not seeking to review the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment into FY 2018. Second, that the court could review the +0.4588 percent positive adjustment and the continuation of the -0.7 percent recoupment adjustment because it was plainly unlawful. Third, and finally, that even if other claims are precluded from review, the claims challenging the Secretary's failure to exercise his "exceptions and adjustments" discretion are not barred by the preclusion statute.

With regard to the first argument that the Providers' challenge was not to the +0.4588 percent positive adjustment for FY 2018 but rather the wrongful continuation of a -0.7 percent recoupment adjustment, the D.C. District Court disagreed and noted that "crafty pleading" and "clever phrasing" could not avoid the bar on judicial review.[56] It reasoned:

> Plaintiffs' assertion that the Secretary improperly determined that TMA § 7(b)(2) permitted him to continue a -0.7% recoupment adjustment into fiscal year 2018 still challenges a determination or adjustment made under TMA § 7(b). Accordingly, judicial review is barred.
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> In order to grant Plaintiffs' requested relief, the Court would need to order the Secretary to make a different adjustment for 2018 than the one that he decided was required. To order the Secretary to make a different adjustment than the one he intended would necessarily require the Court to review an adjustment made under TMA § 7(b), which is prohibited by the preclusion statute. *See* TMA § 7(b)(5). Accordingly, Plaintiffs' claims fall under the clear language of the TMA's preclusion statute.[57]

The Providers also claimed that continuing the -0.7 percent recoupment adjustment into FY 2017 violated TMA § 7(b)(2), which states that an adjustment made under § 7(b)(1)(B) for discharges

[55] *Id.* at 148.
[56] *Id.* at 149.
[57] *Id.* at 150.

in a year cannot be included in the determination of standardized amounts for subsequent years. Since the FY 2017 recoupment adjustment was -1.5% instead of -0.8 percent, the implementation of a +0.4588 adjustment as mandated by Congress fell short when failing to take into account the excess -0.7 percent. Thus, since the adjustment was unlawful, the Providers claimed the preclusion provision did not apply.[58]

The court disagreed, finding that TMA § 7(b)(5) precluded review of *any* determination or adjustment made under § 7(b), not just "proper" ones.[59] More importantly, this argument would completely subsume the *ultra vires* doctrine, which specifically deals with adjustments made "in violation" of a law giving agencies authority:

> Accordingly, Plaintiffs' argument that the Secretary's +0.4588% adjustment violated TMA § 7(b)(2) by leaving in place a recoupment adjustment from 2017 does not overcome the TMA's preclusion statute. Instead, Plaintiffs' argument should be addressed under the ultra vires doctrine[.][60]

The court then turned to the Providers' second argument, that the continuation of the -0.7 percent recoupment adjustment was plainly unlawful – or that the Secretary had acted *ultra vires*:

> Even if the preclusion statute applies to Plaintiffs' claims, the Court may still be able to review those claims under the ultra vires doctrine. Congress has not and cannot limit judicial review to correct a patently unlawful agency action. Under the ultra vires doctrine, an agency action is open to judicial review, even in the face of an applicable preclusion statute, when it "patently misconstrues a statute, disregards a specific and unambiguous statutory directive, or violates a specific command of a statute."[61]

The court acknowledged the Providers' argument: the +0.4588 percent adjustment required by TMA § 7(b)(1)(B)(iii) for fiscal year 2018 was predicated on the 2014 to 2017 recoupment adjustments totaling only -3.2 percent but there had been an additional -0.7 percent recoupment adjustment in 2017. The FY 2018 +0.4588 percent adjustment did not "remove" the FY 2017 -0.7 percent recoupment adjustment, which violated TMA § 7(b)(2) by allowing adjustments from prior years to be included in adjustments for subsequent years. Since the adjustment violates TMA § 7(b)(2), it is "plainly unlawful" or *ultra vires* and subject to judicial review, despite the preclusion provision at TMA § 7(b)(5).[62]

The court disagreed, noting that TMA § 7(b)(1)(B)(iii) *explicitly* required the Secretary to make the +0.4588 percent adjustment, and *only* that adjustment, for FY 2018. It also explained that this very specific mandate was enacted later in time than the general prohibition on continuing recoupment adjustments found in TMA § 7(b)(2). The court concluded:

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[58] *Id.*
[59] *Id.*
[60] *Id.* at 152.
[61] *Id.* (citations omitted).
[62] *Id.* at 153.

> The Secretary's decision to follow the explicit Congressional mandate to implement a +0.4588% adjustment and "not make the adjustment . . . that would otherwise apply" in 2018, which Congress passed with full knowledge of the greater-than-previously-estimated 2017 recoupment adjustment, was not an ultra vires act.[63]

Thus, the court found that the preclusion of administrative or judicial review applied to counts 1, 4, and 5 of the Providers' Complaint. Counts 2 and 3, however, concerned whether the "Secretary failed to adequately explain the rationale for[, and failing to address commenters' questions and requests regarding,] not applying his 'exceptions and adjustments' discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7% adjustment in 2018, offsetting the 2017 -0.7% recoupment adjustment."[64] The court noted it could not review a claim that was "inextricably intertwined" with barred claims.[65] The Secretary argued that he did not use his "exceptions and adjustments" discretion because he determined a +0.7 percent adjustment was prohibited under TMA § 7(b)(1)(B)(iii).[66] The court found, however:

> It is not clear from the 2018 final rule, or from any other source provided by Defendant, that the Secretary considered whether or not to grant a +0.7% adjustment under the "exceptions and adjustments" discretionary authority, despite comments urging him to do so.[67]

The court acknowledged that perhaps the Secretary declined to exercise his discretionary authority because he considered it to be prohibited under the TMA, thus making Counts 2 and 3 "inextricably intertwined" with the other, precluded claims. The court found, however, that the Secretary failed to prove that and, as a result, it had jurisdiction over these two, specific claims.[68]

C. D.C. Circuit Court in Fresno Community Hosp. & Med. Ctr. v. Azar[69]

The Providers appealed to the U.S. Circuit Court for the District of Columbia ("D.C. Circuit Court"). It found that TMA § 7(b)(5) defeats the presumption favoring review of agency action, so the only question was whether the challenged action was "the sort shielded form review."[70] It made the same finding as the D.C. District Court that labeling the challenge as a continued inclusion or failure to reverse a -0.7 percent adjustment is still, in reality, a challenge to an "adjustment" which is barred by TMA § 7(b)(5).[71]

The court next considered the Providers' argument that the -0.6 percent adjustment should be set aside as *ultra vires*, noting that they had the burden of showing "that the Secretary flouted a clear,

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[63] *Id.*
[64] *Id.* at 156-157.
[65] *Id.* at 157.
[66] *Id.*
[67] *Id.* at 158.
[68] *Id.*
[69] 987 F.3d 158 (D.C. Cir. 2021) ("*Fresno v. Cochran*").
[70] *Id.* at 161 (quoting *Amgen Inc. v. Smith*, 357 F.3d 103, 113 (D.C. Cir. 2004).
[71] *Id.* at 161-162.

specific, statutory command."[72] The Providers made the same argument as before the D.C. District Court: that TMA § 7(b)(2) bars the Secretary from allowing any recoupment adjustment to continue into a subsequent year, and by carrying over the -0.7 percent adjustment into 2018, the Secretary violated an explicit statutory prohibition.[73] The D.C. Circuit Court disagreed, noting that the Providers did not object to *other* adjustments being carried over in prior fiscal years. Ultimately, the court found that TMA § 7(b)(2) did not actually forbid the Secretary from carrying over adjustments and affirmed the D.C. District Court's decision.

D. Expedited Judicial Review

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.

E. Preclusion of Board Jurisdiction

As noted above and in the decisions of both the D.C. District Court and D.C. Circuit Court in *Fresno v. Azar*, TMA § 7(b)(5) generally prohibits administrative and judicial review of any determinations or adjustments made pursuant to the TMA. The Providers in these appeals "challenge their FFY 2024 IPPS payments on the grounds that those payments were (and continue to be) improperly reduced due to the ***failure to eliminate*** *the adjustments under paragraph 7(b)(1)(B) of the TMA. . . .*"[74] They also claim that TMA § 7(b)(5) "does not preclude review of CMS' ***continued application*** *of adjustments initially applied* under section 7(b)(1)(B) ***beyond FFY 2023***."[75]

The D.C. District Court directly addressed these arguments and found that the distinction between challenging an adjustment and challenging the failure to eliminate an adjustment amounts to nothing more than "crafty pleading" and "clever phrasing" that cannot avoid the bar on judicial review.[76] In this regard, the Board further notes that, in the preamble to the FY 2024 IPPS Final Rule, the Secretary responded to directly to the issue raised in this appeal and *relied on the TMA*, as amended, in declining "to adjust any payments in FY 2024 [*sic* to] restore any additional amount of the original 3.9 percentage point reduction."[77] Indeed, the permanence of

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[72] *Id.* at 162 (citing *Nyunt v. Chairman, Broad Bd. Of Govs*., 589 F.3d, 449 (D.C. Cir. 2009)).
[73] *Id.*
[74] *E.g.*, PRRB Case 24-1499GC Statement of the Issue at 1 (Feb. 14, 2024) (emphasis added).
[75] *Id.* at 5.
[76] *Fresno v. Azar* at 149.
[77] 88 Fed. Reg. at 58654. The following is an excerpt from this preamble discussion in the FY 2024 IPPS Final Rule at 88 Fed. Reg. 58654 to give the context for the quote:

> *Comment*: Several commenters requested that CMS make a positive adjustment to restore the full amount of the documentation and coding recoupment adjustments in the FY 2024 IPPS final rule which they asserted is required under section (7)(B)(2) and (4) of the TMA . . ., Abstinence Education, and QI [Qualifying Individuals] Programs Extension Act of 2007 (Pub. L. 110–90). Commenters stated that the statute is explicit that CMS may not carry forward any documentation and coding adjustments applied in fiscal years 2010 through 2017 into IPPS rates after FY 2023. Commenters contended that CMS, by its own admission, has restored only 2.9588 percentage points of a total 3.9 percentage point reduction. By not fully restoring the total reductions, commenters

the adjustment made in the FY 2023 IPPS Final Rule was discussed as part of that rulemaking as specifically noted by the Secertary in the preamble to the FY 2023 IPPS Final Rule: "We stated [in the proposed rulemaking] that this would constitute a *permanent* adjustment to payment rates."[78] Accordingly, the Board finds that the Board jurisdiction over this appeal is precluded by TMA § 7(b)(5).

The only claims which survived in *Fresno v. Azar* were those alleging the Secretary should have applied his "exceptions and adjustments" discretion under 42 U.S.C. § 1395ww(d)(5)(I) to make an additional +0.7 percent adjustment in 2018. The Providers in this group appeal have not cited 42 U.S.C. § 1395ww(d)(5)(I) or discussed the Secretary's "exceptions and adjustments" discretion in any capacity. Board Rule 7.2.1 (Nov. 2021) requires that, for each issue raised in an appeal request, a Provider must submit a concise issue statement describing, *inter alia*, the controlling

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> believe that CMS is improperly extending payment adjustments beyond the FY 2023 statutory limit. A commenter stated that, even if CMS disputes it is required to make such an adjustment, CMS should use its special exceptions and adjustments authority to address the shortfall.
> *Response*: As of FY 2023, CMS completed the statutory requirements of section 7(b)(1)(B) of Pub. L. 110–90 as amended . . . . As we discussed in the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 through 44795), the FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 through 58445) and in prior rules, we believe section 414 of the MACRA and section 15005 of the 21st Century Cures Act set forth the levels of positive adjustments for FYs 2018 through 2023. We are not convinced that the adjustments prescribed by MACRA were predicated on a specific adjustment level estimated or implemented by CMS in previous rulemaking. We see no evidence that Congress enacted these adjustments with the intent that CMS would make an additional +0.7 percentage point adjustment in FY 2018 to compensate for the higher than expected final ATRA adjustment made in FY 2017, nor are we persuaded that it would be appropriate to use the Secretary's exceptions and adjustments authority under section 1886(d)(5)(I) of the Act **to adjust payments in FY 2024 restore any additional amount of the original 3.9 percentage point reduction, given Congress' directive regarding prescriptive adjustment levels under section 414 of the MACRA and section 15005 of the 21st Century Cures Act**. Accordingly, in the FY 2018 IPPS/LTCH PPS final rule (82 FR 38009), we implemented the required +0.4588 percentage point adjustment to the standardized amount for FY 2018. In the FY 2019 IPPS/LTCH PPS final rule (FY 2019 final rule) (83 FR 41157), the FY 2020 IPPS/LTCH PPS final rule (FY 2020 final rule) (84 FR 42057), the FY 2021 IPPS/LTCH PPS final rule (FY 2021 final rule) (85 FR 58444 and 58445), the FY 2022 IPPS/LTCH PPS final rule (FY 2022 final rule) (86 FR 44794 and 44795), and the FY 2023 IPPS/LTCH PPS final rule (FY 2023 final rule) (87 FR 48800), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, FY 2022 and FY 2023, respectively. As discussed in the FY 2023 final rule, the finalized 0.5 percentage point positive adjustment for FY 2023 is the final adjustment prescribed by section 414 of the MACRA.

(Italics emphasis in original and bold and italics emphasis added.)

[78] 87 Fed. Reg. at 48800 (emphasis added) . Similarly, the Board notes that the FY 2023 IPPS Proposed Rule included the following discussion in the preamble at 87 Fed. Reg. 28108, 28126 (May 10, 2022) (emphasis added):

> In the FY 2019 IPPS/LTCH PPS final rule (83 FR 41157), the FY 2020 IPPS/ LTCH PPS final rule (84 FR 42057), FY 2021 IPPS/LTCH PPS final rule (85 FR 58444 and 58445), and the FY 2022 IPPS/LTCH PPS final rule (86 FR 44794 and 44795), consistent with the requirements of section 414 of the MACRA, we implemented 0.5 percentage point positive adjustments to the standardized amount for FY 2019, FY 2020, FY 2021, and FY 2022, respectively. *We indicated the FY 2018, FY 2019, FY 2020, FY 2021, and FY 2022 adjustments were **permanent** adjustments to payment rates*. We also stated that we plan to propose a future adjustment required under section 414 of the MACRA for FY 2023 in future rulemaking.
>
> ****
>
> Consistent with the requirements of section 414 of the MACRA, we are proposing to implement a 0.5 percentage point positive adjustment to the standardized amount for FY 2023. *This would constitute a **permanent** adjustment to payment rates*.

authority, why the adjustment is incorrect, and the basis for jurisdiction before the Board. The Providers failed to make this argument in their requests for hearing or Request for EJR and, as such, the Board will not address or consider it as part of the appeal.

Based on the foregoing, the Board finds that, pursuant to TMA § 7(b)(5), it lacks substantive jurisdiction to review the issue appealed in this group and is, therefore, dismissing the case and denying the Request for EJR for the same reason.[79]

Accordingly, the Board closes this CIRP group case and removes it from the Board's docket. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

Clayton J. Nix, Esq.
Robert A. Evarts, Esq.
Kevin D. Smith, CPA
Ratina Kelly, CPA
Nicole E. Musgrave, Esq.

FOR THE BOARD:

3/28/2024

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson Leong, FSS

[79] The Board recognizes that the Providers maintain the Board should find jurisdiction over the instant appeal "consistent with the Board's previous grans of EJR" for the cases underlying the *Fresno v. Azar* litigation. However, those prior determination did not address the TMA preclusion provisions and it is clear that both the D.C. District Court and the D.C. Circuit Court specifically found that the TMA preclusion provisions were applicable to those appeals. Consequently, the Board finds that it erred in finding jurisdiction in those earlier cases as supported by the analysis in this determination and the Courts' decisions in the *Fresno v. Azar* litigation.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Board Determination – Dismissal of Untimely Filed Group***
Beaumont Health CY 2020 Medicare Part C Days CIRP Group
PRRB Case No. 24-1292C

Dear Ms. Liu and Mr. Lamprecht:

The Provider Reimbursement Review Board (the "Board") has reviewed the above-captioned common issue related party ("CIRP") group and finds impediments to jurisdiction over the providers that formed the group. The pertinent facts and the Board's determination are set forth below.

Background:

On February 14, 2024, Beaumont Health ("Beaumont"/Representative) filed the "Beaumont Health CY 2020 Medicare Part C Days CIRP Group" under Case No. 24-1292GC. The group was formed with three providers that filed from Notices of Program Reimbursement ("NPRs"):

Provider Name/No.	**NPR**	**# of Days**
Beaumont Hospital Wayne (Prov. No. 23-0142)	5/31/2023	259
Beaumont Hospital Grosse Pointe (Prov. No. 23-0089)	6/1/2023	258
Beaumont Hospital Trenton (Prov. No. 23-0176)	3/20/2023	331

On February 16, 2024, the Medicare Contractor filed its "Rule 15" review letter and requested the group be dismissed because "[a]ll providers identified with the appeal request were filed beyond 180 days from the receipt of the determinations."

Board Determination:

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

Specifically, 42 C.F.R. § 405.1835(a)(3) indicates that, unless the Provider qualifies for a good cause extension, the Board must receive a Provider's hearing request no later than 180 days after the date of receipt of the final determination, with a five-day presumption for mailing. In this case, the Medicare Contractor issued the NPRs for Beaumont Hospital Wayne on May 31, 2023; Beaumont Hospital Grosse Pointe on June 1, 2023; and Beaumont Hospital Trenton on March 20, 2023. The 185th days fell on Saturday, December 2, 2023, Sunday, December 3, 2023 and Thursday, September 21, 2023, respectively.[1] The Direct Adds for the three Providers that formed the group were not filed until Wednesday, February 14, 2024, which was well beyond 185 days after the issuance of the final determinations.[2]

As the direct addition of the three providers used to form Case No. 24-1496GC: Beaumont Hospital Wayne, Beaumont Hospital Grosse Pointe and Beaumont Hospital Trenton, do not meet the regulatory filing requirements. Consequently, the Board hereby dismisses the group. Review of this determination is available under the provisions of 42 U.S.C. § 1395oo(F) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

3/29/2024

X Ratina Kelly

Ratina Kelly
Board Member
Signed by: Ratina S. Kelly -S

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

[1] Based on the Federal Rules of Procedure, if the last day of the period is a Saturday, Sunday, holiday, or court closure, the period continues to run until the next day that is not a Saturday, Sunday, holiday, or court closure.
[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 must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination." There was no allegation of good cause filed with the request for a group appeal or with any of the participant's support documents.