DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Thomas Knight
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Concord, CA 94520-2546

RE: ***EJR Determination***
14-3998GC – *NorthBay Healthcare FY 2007 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group*

Dear Mr. Knight:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 29, 2022 request for expedited judicial review ("EJR") filed by the Group Representative, Toyon Associates, Inc. ("Toyon"), in the above-referenced common issue related party ("CIRP") group appeal involving NorthBay Healthcare ("NorthBay"). On May 27, 2022, the Board issued a "Notice of When 30-Day Period Begins", notifying the provider that the Board would issue its decision regarding EJR, within 30 days of rendering a determination on jurisdiction. The issuance of this determination completes the Board jurisdictional review process and the Board is concurrently issuing its determination on the EJR request as the Board is familiar with the legal issues raised in the EJR request and has previously issued similar EJR determinations for those legal issues (both for this Group Representative as well as others).

I. Issue in Dispute

This CIRP group was created after Toyon requested that a NorthBay CIRP group be established for the following hospitals:

1. NorthBay Medical Center, Prov. No. 05-0367, FYE 12/31/2007 ("NB Medical"); and
2. VacaValley Hospital, Prov. No. 05-0680, FYE 12/31/2007 ("VacaValley").

Specifically, Toyon requested that a NorthBay CIRP group be established and that these two providers be transferred from the optional group under Case No. 13-0484G to this new CIRP group. On August 19, 2014, the Board granted Toyon's request and established the new CIRP group under Case No. 14-3998GC and transferred the two providers into that new CIRP group. Toyon attached to their group appeal request a copy of the individual appeal issue statements for NB Medical and VacaValley, which stated the issue in dispute, identically, as follows:

> The Provider disputes the SSI percentage developed by [the Centers for Medicare & Medicaid Services ("CMS")] and utilized by the [Medicare Administrative Contractor ("MAC")] in their updated calculation of Medicare DSH payment. On May 3, 2010

> CMS published CMS Ruling 1498-R pertaining to three Medicare DSH issues, one of which requires the inclusion of Medicare Part A non-covered days (such as exhausted benefit days and Medicare secondary payer days) in the SSI ratio of the Medicare DSH payment calculation.
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> The Provider contends CMS' new interpretation of including Medicare Dual Eligible Part A Days in the SSI ratio issued on March 16, 2012 is tantamount to retroactive rule making, which the D.C. Circuit held impermissible in the *Northeast Hospital* decision. The Secretary did not validly change her interpretation of the DSH calculation prior to FFY 2013, and because there is "no statute that authorizes the Secretary to promulgate retroactive rules for DSH calculations," *id.,* the Secretary cannot impose her new interpretation on the DSH payment calculation challenged in this case. The Provider's position is supported by the federal district court decision in *Allina Health Services, et al, v. Kathleen Sebelius, Secretary, U.S. Department of Health and Human Services* (Civil Action No. 10-1463 (RMC)). The Provider maintains the position all unpaid Medicare Dual Eligible Part A Days should be included in the Medicaid patient day ratio of the Medicare DSH payment calculation. The applicable Medicare regulations are 42 C.F.R. 412.106 and 42 C.F.R. 412.624.[1]

For NB Medical, the documentation included with the group appeal request indicates that the estimated Medicare reimbursement at issue is $90,524 based upon the exclusion of 115 Medicare Dual Eligible Part A Days from the SSI Ratio and inclusion of 115 additional Medicare Dual Eligible Part A Days in the Medicaid patient day ratio of the Medicare DSH payment calculation.[2]

Similarly, for VacaValley, the documentation included with the group appeal request indicates the estimated Medicare reimbursement at issue is $204,311 based upon the exclusion of 270 Medicare Dual Eligible Part A Days from the SSI Ratio and inclusion of 270 additional Medicare Dual Eligible Part A Days in the Medicaid patient day ratio of the Medicare DSH payment calculation.[3]

In the Providers' request for EJR, they frame the legal question as follows. The Providers, who are within the Ninth Circuit's jurisdiction, request a determination from the Board whether, in light of the Ninth Circuit's decision in *Empire Health Foundation for Valley Hospital Center v. Azar,* 958 F.3d 873 (9th Cir. 2020) ("*Empire*"), it has the authority to instruct the MAC to

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[1] NorthBay Medical Center Individual Appeal Request, February 7, 2013, as included in the August 14, 2014 group appeal request to establish 14-3998GC at 20.
[2] *Id.* at 20.
[3] VacaValley Hospital Individual Appeal Request, February 7, 2013, as included in the August 14, 2014 group appeal request to establish 14-3998GC, at 59.

recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as being "entitled to benefits under Part A" for purposes of both the Medicare and Medicaid DSH fractions.[4] If the Board determines it lacks that authority, the Board should grant EJR.[5] If the Board believes it has that authority by virtue of the Ninth Circuit's decision, it should remand to the MAC with instructions to recalculate the Providers' DSH payments by no longer treating days that are not entitled to Part A payment as nonetheless being "entitled to benefits under Part A" consistent with the ruling in *Empire.*[6]

Thus, it is clear from the Providers' issue statements that the Medicare Dual Eligible Part A Days in the SSI ratio issue impacts ***both*** the Medicare/SSI fraction and the Medicaid fraction of the DSH payment calculation. When framing issues for adjustments involving multiple components, Board Rule 8.1 requires that "each contested component must be appealed as a separate issue and described as narrowly as possible." Further, the statute and regulations governing group appeals specifically note that a provider has a right to a Board hearing as part of a group appeal with other providers "***only if*** . . . [t]he matter at issue in the group appeal involves a ***single*** quest of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group[.]"[7] Similarly, "[w]hen the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case."[8] As discussed below in Section IV.B, the Board concludes that the Providers' challenge to the application of Dual Eligible , Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions is two separate issues, even though they are identified in the Providers' appeal and EJR requests, and OH CDMS, as one combined issue. In this regard, the Board notes that it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction.[9]

For the sake of judicial economy, the Board is hereby initially bifurcating this CIRP Group Appeal into the following cases, as reflected in the attached Schedules of Providers:

- 14-3998GC(A) – NorthBay Healthcare 2007 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/SSI Fraction

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[4] Request for Expedited Judicial Review, 1 (Apr. 29, 2022) ("EJR Request").
[5] *Id.*
[6] *Id.* at 1-2.
[7] 42 C.F.R. § 405.1837(a)(2). *See also* 42 U.S.C. 1395oo(b) (noting that a group appeal is proper "***only if*** the matters in controversy involve a common question of fact or interpretation of law or regulations . . .").
[8] 42 C.F.R. § 405.1837(f)(2)(ii).
[9] The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.

- 14-3998GC(B) – NorthBay Healthcare 2007 Inclusion of Dual Eligible Part A Days in SSI Ratio Issued 3/16/2012 CIRP Group/Medicaid fraction[10]

The Board has reviewed the jurisdictional documentation for each participant for both issues, and has determined (as discussed in Section IV.A below), that NB Medical does not have a valid appeal of the Medicaid fraction. How that impacts the bifurcation of the appeals will be addressed with the jurisdictional determination.

Accordingly, the Board is treating this EJR request as a consolidated EJR request cover both issues, as discussed below.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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").[11] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[12]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[13] 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.[14]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[15] 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.[16] The DPP is defined as the sum of two fractions expressed as percentages.[17] 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."

[10] As these cases have the same record up to this point and there will be no further proceedings before the Board following this decision, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time. Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant. *See also infra* note 77.
[11] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[12] *Id.*
[13] *See* 42 U.S.C. § 1395ww(d)(5).
[14] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[15] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[16] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[17] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The statute, 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 . . . .[18]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[19]

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.[20]

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.[21]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[22] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid

[18] (Emphasis added.)
[19] 42 C.F.R. § 412.106(b)(2)-(3).
[20] (Emphasis added.)
[21] 42 C.F.R. § 412.106(b)(4).
[22] 68 Fed. Reg. 27154, 27207 (May 19, 2003).

fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[23]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[24] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[25] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[26]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[27] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[28] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[29]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[30] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended. [31] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital

[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.* at 27207-27208.
[27] *Id.* at 27207-08.
[28] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[29] 68 Fed. Reg. at 27208.
[30] *Id.*
[31] *Id.*

would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[32]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[33] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[34]
On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[35] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[36]
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> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator

[32] *Id.*
[33] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[34] *Id.*
[35] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[36] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[37]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[39] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *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 and SSI, excluding those patients who received only State supplementation . . .[40]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[41]

[37] *Id.* at 49099 (emphasis added).
[38] *Id.*
[39] *See id.* at 49099, 49246.
[40] (Emphasis added.)
[41] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[42]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[43] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[44]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[45] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[46] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[47] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[48] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

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[42] *Id.*
[43] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[44] (Citations omitted and emphasis added.)
[45] 317 F. Supp. 3d 168 (D.D.C. 2018).
[46] *Id.* at 172.
[47] *Id.* at 190.
[48] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[49] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[50] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[51] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[52]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[53] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[54] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[55] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[56] and that the regulation is procedurally invalid.[57]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[58] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[59] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[60] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in

[49] *See* 2019 WL 668282.
[50] 718 F.3d 914 (2013).
[51] 657 F.3d 1 (D.C. Cir. 2011).
[52] 718 F.3d at 920.
[53] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[54] *Id.* at 1141.
[55] *Id.*
[56] *Id.* at 1162.
[57] *Id.* at 1163
[58] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[59] *Id.* at 884.
[60] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[61] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[62] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[63] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[64] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[65] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. <u>Providers' Position</u>

The Providers are challenging the inclusion of certain non-covered (Part A exhausted or Medicare secondary payor) patient days in the Medicare (or SSI) fraction.[66] The Providers believe that the Ninth Circuit's decision in *Empire* entirely vacates the Secretary's 2005 Rule, discussed above, on a nationwide basis and that, at a minimum, the *Empire* ruling is binding for hospital's in the Ninth Circuit as the Providers argue CMS has seemed to recognize.[67] The hospitals in this group appeal are within the Ninth Circuit's jurisdiction, and thus the Providers argue that that decision is binding and remains in effect until the Supreme Court determines otherwise because the government did not request a stay of the decision pending Supreme Court review.[68] The Providers argue that if the Board believes it is bound by the Ninth Circuit's

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[61] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[62] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[63] *Id.* at 886.
[64] *Id.*
[65] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).
[66] EJR Request, at 1-3.
[67] *Id.* at 2-3, *citing* Pub. 100-09 Medicare Contractor Beneficiary and Provider Communications, Transmittal 11127 (Nov. 16, 2021) (calculating the 2019 SSI fractions for hospitals within the Ninth Circuit consistent with *Empire*); Transmittal 11276 (Feb. 24, 2022) (calculating the same for 2020).
[68] *Id.* at 1-3.

decision, the Providers request that the Board remand this case to the MAC to recalculate all of the Providers' DSH payments consistent with the *Empire* ruling in which CMS' 2005 regulation was vacated and CMS' pre-2005 regulation under which only "covered" Part A days are treated as being "entitled to benefits under Part A" was reinstated.[69]

If instead, the Board believes it continues to be bound by CMS' 2005 regulation, and/or CMS Ruling 1498R, the Providers request that the Board grant EJR on this issue.[70]

IV. Decision of the Board

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

A. Jurisdiction for Appeals of Cost Report Periods Ending Prior to Dec. 31, 2008

The Providers in Case Nos. 14-3998GC(A) and 14-3998GC(B) have appealed cost reports with fiscal year ends ("FYEs") prior to December 31, 2008, namely, cost reports with FYEs of June 30, 2007.

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending prior to December 31, 2008 the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming an issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hosp. Ass'n v. Bowen*.[71] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[72]

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR.[73] The Board notes that the participant

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[69] *Id.*
[70] *Id.*
[71] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[72] *Bethesda at 1258-59.*
[73] See 42 C.F.R. § 405.1889(b)(1) (2008).

that appealed from the revised NPR appeal included within this EJR request, was issued after August 21, 2008.

1. *Jurisdiction for RNPR – NorthBay Medical Center (12/31/2007)*

NB Medical appealed from a revised NPR dated August 20, 2012. The reopening notice date March 21, 2012 and the Audit Adjustment report shows that the revised NPR was issued to update the SSI percentage to the most accurate published ratio.[74] The SSI percentage decreased 0.41, from 17.74 to 17.33. The revised NPR did not adjust either the Medicaid days or the Medicaid fraction and, as such, it is clear that the revised NPR did not adjust Dual Eligible days in the Medicaid percentage. Rather, the revised NPR only adjusted dual eligible days in the SSI percentage (aka SSI fraction or Medicare fraction) because the data match process used to gather data for the SSI percentage[75] was rerun generating a new and different SSI percentage where the Board must necessarily assume that there was a change in the underlying month-by-month data and that the no-pay Part A days included in that month-by-month data was also changed.[76] The Board finds it has jurisdiction over the SSI percentage portion of the appeal but denies jurisdiction over the inclusion of dual eligible days in the Medicaid percentage of the SSI fraction because the Medicaid percentage was not adjusted in the revised NPR.

The regulation, 42 C.F.R. § 405.1889, limits the appeal of revised NPRs to issues which were adjusted as part of the cost report reopening. The regulation states that:

> 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 . . . § 405.1835 . . .of this subpart are applicable.

[74] The following website is where SSI percentage data is published for hospitals and shows updated SSI percentages for FY 2007 being published in March 2007: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh. This confirms that the revised NPR used an updated SSI percentage created by rerunning of the data matching process.
[75] The data matching process used to generate data underlying SSI percentages is gathered on a month-by-month basis per 42 C.F.R. § 412.106(b)(2) following the data matching process described and adopted in the final rule published at 75 Fed. Reg. 50042 (Aug. 16, 2010).
[76] This situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, 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 from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "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 or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

> (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.

Since, pursuant to 42 C.F.R. § 405.1842(a) jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board hereby denies jurisdiction over the NB Medical in Case No. 14-3998GC(B) and, therefore, also denies the request for EJR for NB Medical as part of the Medicaid fraction group. As dismissal of NB Medical leaves VacaValley as the sole participant in Case No. 14-3998GC(B), the Board has converted the group case to an individual appeal, Case No. 14-3998(B), for VacaValley, FY 12/31/2007, with the sole issue of Dual Eligible Days – SSI Fraction.[77]

2. *Jurisdictional Determination for the Remaining Provider*

The Board has determined that the other participant, VacaValley 12/31//2007, involved with the instant own-motion EJR appealed from an original NPR. The Board finds it has jurisdiction over this provider, as governed by the decision in *Bethesda*. In addition, the participants' documentation, for Case No. 14-3998GC(A), shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal[78] and $10,000 for 14-3998(B) for VacaValley and that the appeals were timely filed. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Board's Analysis of the Appealed Issue

First, the Providers assert that the *Empire* ruling is binding for hospitals in the Ninth Circuit as the Providers argue that CMS has seemingly recognized that fact in CMS Transmittal No. 11127, which addresses the SSI/Medicare Beneficiary Data to be used in the calculation of DSH adjustments.[79] That transmittal directs Medicare Contractors to include only "covered days" in the SSI ratio, and provides as follows: "For IPPS hospitals in the Ninth Circuit's jurisdiction (Alaska, Arizona, California, Hawaii, Idaho, Montana, Nevada, Oregon and Washington), these ratios include only "covered days" to reflect the decision of the 9th Circuit in Empire Health Foundation v. Azar (currently pending before the Supreme Court), to preliminarily settle cost

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[77] As noted at *supra* note 10, these cases have the same record up to this point and there will be no further proceedings before the Board following this decision. Accordingly, the Board has opted for purposes of administrative efficiency not to create a separate case number within OH-CDMS at this time for Case No. 14-3998(B). Should additional proceedings before the Board occur in these cases on remand to the Board, then the Board would do so at that time, as appropriate and relevant.
[78] *See* 42 C.F.R. § 405.1837.
[79] Transmittal No. 11127 (Nov. 16, 2021), and related MLN Matters Article No. MM12516, are available online at: https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Transmittals/r11127com.

reports."[80] However, that transmittal and the transmittal issued the following year to which the Providers cite, apply only for FY 2019 and FY 2020, respectively.[81] Importantly, the purpose of calculating those cost reports pursuant to *Empire* is to "preliminarily settle cost reports," and the transmittal notes that the Ninth Circuit's decision is currently pending before the Supreme Court. The cost reports at issue in this appeal have FYEs of June 30, 2008, and thus those transmittals are not applicable to this appeal.

Further, 42 C.F.R. § 405.1867 specifies that "[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* . . . ."[82] Here the Secretary has not yet acquiesced to the Ninth Circuit's decision in *Empire* and has not otherwise retracted or revised the regulation at issue. Consequently, the Board finds that it continues to be bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Provider, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issues and calendar year under appeal in this case.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[83] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[84]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have

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[80] *Id.*
[81] *See id.*
[82] (Emphasis added.)
[83] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[84] *Id.* (emphasis added).

Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[85] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[86] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on

[85] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[86] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.

> its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[87]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[88] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the numerator of the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter at issue for the subject year and that the Providers in Case No. 14-3998GC(A) and Case No. 14-3998(B) for VacaValley[89] are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal question in Case No. 14-3998GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid; and the legal question in Case No. 14-3998(B) of what policy should then apply which, per

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[87] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.

[88] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

[89] Note Case No. 14-3998(B) is an individual appeal for VacaValley as it relates to the inclusion of no-pay Part A dual eligible days in the numerator of the Medicaid fraction as explained at *supra* note 77 and accompanying text.

the 9th Circuit decision in *Empire* but contrary to the Provider's position,[90] 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[91]) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible.

Accordingly, the Board finds that the questions in Finding 4 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and grants the Providers' consolidated request for EJR for the issues and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in these appeals, the Board hereby closes the appeals and removes them from the Board's docket.

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:

6/1/2022

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Wilson C. Leong, FSS

[90] The Board notes that the Provider is located in the Ninth Circuit.
[91] 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.

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

Pam VanArsdale
National Government Services, Inc. (J-6)
MP: INA 101-AF-42
P.O. Box 6474
Indianapolis, IN 46206-6474

Deborah Mayland-Poyzer
Fairview Health Services
400 Stinson Boulevard NE
Minneapolis, MN 55413-2613

RE: ***Jurisdictional Determination***
13-0937GC Fairview Health Services 2006 Medicaid Fraction for Medicare HMO Days CIRP

Specifically: Fairview Lakes Reg. Med. Center (Prov. No.: 24-0050)
Fairview Southdale Hospital (Prov. No. 24-0078)
University of Minnesota Med. Center (Prov. No. 24-0080)

Dear Ms. VanArsdale and Ms. Mayland-Poyzer:

The Provider Reimbursement Review Board ("PRRB" or "Board") has reviewed the above referenced appeal in response to the Medicare Contractor's ("MAC") Jurisdictional Challenge over the three Providers that were directly added to the group from receipt of their corrected Notices of Program Reimbursement ("RNPRs"). The Board's decision is set forth below.

Background:

On March 4, 2013 Fairview Health Services filed a request for a group appeal for the Medicaid Fraction for Medicare HMO Days issue for the fiscal year ends ("FYE") 2006 through 2008. The Board acknowledged Fairview's request by establishing separate group appeals for each of the three FYEs. The FYE 2006 group was assigned Case No. 13-0937GC and was formed with the following participants:

1. Fairview Lakes Reg. Med. Center (FYE 12/31/2006) appealing from a RNPR dated September 11, 2012;

2. Fairview Southdale Hospital (FYE 12/31/2006) appealing from a RNPR dated October 16, 2012; and

3. University of Minnesota Med. Center (24-0080) appealing from a RNPR dated October 23, 2012.

The Medicare Contractor filed a Jurisdictional Challenge (April 5, 2013) regarding the Part C Days in the Medicaid Fraction issue.

Medicare Contractor's Jurisdictional Challenge

The Medicare Contractor asserts that the Board does not have jurisdiction over the Part C days in the Medicaid fraction issue for these three Providers because there were no audit adjustments proposed that related to the issue. The Medicare Contractor argues that the lone issue addressed in the reopenings was the Medicare Fraction SSI Percentage. Therefore, the Providers have failed to preserve their right to claim dissatisfaction with the Medicaid fraction because they failed to challenge the issue from receipt of the original NPRs issued in 2008.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2012), 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.

At issue in this dispute is whether the Provider meets the dissatisfaction requirement for Board jurisdiction.

Part C Days in the Medicaid Fraction

The Board finds it has jurisdiction over the Providers' appeals from the RNPRs for the Part C Days issue in both the SSI/Medicare and Medicaid Fractions.

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

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

Additionally, 42 C.F.R. § 405.1889[1] 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

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[1] *See also 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).

> 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.

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

> (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 Group Issue statement describes the Part C Days in the Medicaid fraction issue as follows:

> The provider argues the Secretary did not follow Congressional intent of the DSH fraction with regards to the Medicare Advantage program ((CFR 422.50(a)(1)) and (42 USC 1395ww(d)(5)(F)(vi)(I) and (II)) or apply appropriate procedures when introducing new rulemaking (42 USC 1395hh(a)(4). The Secretary had conflicting outcomes in the 2003 Notice of proposed rulemaking and 2004 notice final rulemaking in regards to the handling of the Medicare Advantage days in both the Medicare and Medicaid fractions. The final rulemaking failed to provide sufficient explanation on why the opposite interpretation was arrived between the two rulemaking documents or address the financial implication being imposed to providers.

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[2] (Emphasis added.)

> No audit adjustments are made on the final Notice of Program Reimbursement relating to this issue because the Provider self-disallowed Medicare Advantage patient days in the Medicaid fraction based on fiscal intermediary instructions and the Secretary's interpretation and rulemaking clarification written in Federal Register Vol. 96, No. 154, page 49099.[3]

The Board finds that the Providers have cited to an adjustment of the DSH SSI percentage in the Medicare/SSI Fraction for Medicare HMO Days CIRP Group (Case No. 13-0942GC) and per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction.[4] Thus, pursuant to *Allina*, if the provider were to be successful in its regulatory challenge, then the Part C days would have to be moved from the SSI fraction to the Medicaid fraction. Accordingly, the Board finds that it has jurisdiction over the complete Part C days issue as the Providers have met the dissatisfaction requirement for this issue.

The Board will issue a remand pursuant to CMS Ruling 1739-R as it applies to the Part C Days in the Medicaid fraction issue in this case, along with the Part C Days in the SSI fraction issue which is pending in Case No. 13-0942GC, under separate cover.

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

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

FOR THE BOARD

6/3/2022

Clayton J. Nix
Chair
Signed by: PIV

cc: Wilson Leong, Federal Specialized Services

[3] The same issue statement was used in the formation of the three Medicaid Fraction Medicare HMO Days Groups, Case Nos. 13-0937GC, 13-0938GC and 19-0939GC. *Model Form B – Group Appeal Request* (March 4, 2013), Tab 2.
[4] Specifically, *Allina* states "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)." 746 F.3d at 1108.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Board Response: Request for Jurisdictional Decision***
Hartford Hospital (Prov. No. 07-0025)
FYE 9/30/2012
Case No. 16-0846

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") received the "Request for Jurisdictional Decision" dated May 11, 2022, in which Quality Reimbursement Services ("QRS"), as the designated representative, requests that the Board "clarify it previous jurisdictional determination issued on November 17, 2021" and describes that determination as the Board finding that "it had jurisdiction over the Crossover Bad Debt issue with respect to the adjustments made by the MAC in the NPR issued on August 03, 2015." QRS goes on to explain, that "the provider is pursuing crossover bad debts which were not claimed or disallowed during the previous audit of the providers submitted cost report," and requests that the Board "clarify whether those additional crossover bad debts, *which are the only bad debts being pursued in the appeal*, are included in the Board's jurisdiction."[1]

The Board previously found in its decision dated November 17, 2021, that the Board "has jurisdiction over a limited aspect of the Bad Debts issue." Specifically, the Board ruled that "[t]he Provider in this case only had appeal rights related to those crossover bad debts that were ***actually*** adjusted, if any."[2] In making this ruling, the Board noted that none of the audit adjustments cited in the appeal request for his issue dealt with or concerned *crossover* bad debts and were ***not*** relevant for purposes of jurisdiction[3] and that the protested amount adjusted in Audit Adjustment No. 31 does ***not*** relate to bad debts (much less crossover bad debts) but rather related to the SSI Percentage and Medicaid eligible days.[4] Notwithstanding, the Board reviewed the audit adjustment report and identified two audit adjustments not cited by the Provider that did relate to crossover bad debts, namely Audit Adjustment Nos. 39 and 40 and made the following findings regarding those adjustments:

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[1] (Emphasis added.)
[2] (Emphasis in original.)
[3] Specifically, for Issue 8, Crossover Bad Debts, the appeal request cites Audit Adjustment Nos. 28, 31, 32, 33, 36, 45, 47, 63, 64, 65 and S-D; however, none of these adjustments dealt with or concerned ***crossover*** bad debts and, thus, could not serve as a basis for appeal of the crossover bad debts issue.
[4] *See* Exhibit C-6.

> Accordingly, the Board finds that there were adjustments related to crossover bad debts and that the Provider has appeal rights based on these adjustments (No. 39 for $2,696 and No. 40 for $57,555)[5] ***but only*** for the amount of the adjustments as they relate to *specific* crossover bad debts, if any, included within those adjustments. . . . If it turns out that Audit Adjustment Nos. 38 [*sic* 39] and 40 do ***not*** contain some or all of the crossover bad debts in dispute, then provider has no appeal rights under 42 C.F.R. § 405.1835(a) for any crossover bad debts in dispute which were not part of Audit Adjustment Nos. 39 or 40.[6]

Thus, the Board previously found that the it ***only*** had jurisdiction over those *crossover* bad debts that were ***actually*** adjusted in Audit Adjustment Nos. 39 and 40. Here, QRS has certified that the Provider is ***only*** pursuing crossover bad debts which "were ***not*** claimed or disallowed during the previous audit of the providers submitted cost report" and requests that the Board "***clarify*** whether those additional crossover bad debts, *which are the **only** bad debts being pursued in the appeal*, are included in the Board's jurisdiction." From the Board's perspective, it is unclear what QRS needs "clarify[ied]." The Board's ruling was abundantly clear that it had jurisdiction ***only*** over those crossover bad debts that were adjusted in Audit Adjustments 39 and 40 and that the Provider had "no appeal rights under 42 C.F.R. § 405.1835(a) for any crossover bad debts in dispute which were not part of Audit Adjustment Nos. 39 or 40."

The Board further notes that, under the regulations in effect when the FY 2012 cost report at issue was filed, the Provider had to either claim the cost at issue on the cost report or follow the protest requirement in order for the Board to have jurisdiction pursuant to 42 C.F.R. § 405.1835(a)(1) (2012). Subsequent to the cost report filing, CMS modified the presentment and protest requirements of § 405.1835(a)(1) by issuing CMS Ruling 1727-R ("Ruling 1727-R"). However, CMS Ruling 1727-R is not applicable to the unclaimed crossover bad debts at issue because the Provider was not barred by a regulation or other payment policy from claiming the days on its cost report and there is no indication in the record that the Provider had a good faith belief that the crossover bad debts at issue were not be allowable under Medicare payment policy.[7] As such , it is clear that the Board has no jurisdiction over the additional unclaimed crossover bad debts at issue.[8]

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[5] Exhibit C-3 at 17-18.

[6] (Footnote and emphasis in oridiginal.)

[7] *See* Provider's Final Position Paper at 9 (June 13, 2021) (stating "The Provider can furnish a listing which documents inpatient deductible and coinsurance amounts billed an not paid by the State of Connecticut. These additional Medicare crossover bad debts are supported by remittance advices from the Medicaid Intermediary proving that these amounts were billed, but the deductible and coinsurance amounts were not paid. These bad debts are in compliance with Section 322 of the PRM, Part I and were not claimed on any previous fiscal year cost reports.").

[8] The Board recognizes that, notwithstanding the lack of jurisdiction under 42 U.S.C. § 1395oo(a), there historically has been an issue of whether the Board could exercise discretion under 42 U.S.C. § 1395oo(d) to still hear the bad debt issue as it relates to the unclaimed additional crossover bad debts at issue. In this regard, the Board recognizes that there are a number of federal cases that discuss the Board's discretionary authority under § 1395oo(d) in fairly broad terms (including *MaineGeneral* and the Supreme Court's decision in *Bethesda*). The Board discusses some of these cases in its 2013 decision in *St. Vincent Hosp. & Health Ctr. V. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2013-D39 at 13-16 (Sept. 13, 2013), *declined review*, CMS Adm'r (Oct. 25, 2013) ("*SVHHC*"). However, the Board also recognizes that, in the final rule issued on May 23, 2008, the Secretary revised the Board's regulations to limit the

Finally, the Board recognizes that the Medicare Contractor has pending objections to the Provider's failure to timely file its witness list and failure to properly explain the nature of the testimony for the sole witness listed therein. In raising its objection, the Medicare Contractor cited to Board Rule 28 which requires that witness list be filed 30 days prior to hearing and that the list "*must* identify each witness, the witness's relationship to the party, and the nature of the witness's testimony."[9] While it is clear that the Provider ***failed** to timely* file the witness list and that the Provider's as-filed witness list *was **materially** deficient* in that it failed to "identify . . . the nature of the witness's testimony," the Board need not determine whether to sustain the objection and exclude the Provider's witness (or take any other remedial action) since the case has been dismissed and no hearing will be held. The Board reminds QRS that, as stated in Board Rule 28, "[a] party's failure to timely file a witness list ***will** result* in the Board taking appropriate actions under 42 C.F.R. § 405.1868 (*e.g., **excluding** witnesses*)."[10]

*****

In summary, the Board finds that the crossover bad debts issue under appeal was dismissed in its November 17, 2021 jurisdictional decision since the crossover bad debts at issue relates solely to unclaimed debts that were neither adjusted nor disallowed in the NPR at issue. As there are no remaining issues in Case No. 16-0846, the Board hereby closes it and removes it from the Board's docket.

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For the Board:

6/3/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Danelle Decker, National Government Services, Inc. (J-K)

Board's authority under 42 U.S.C § 1395oo(d) through the promulgation of the regulation at 42 C.F.R. § 405.1869(a) (*see* 73 Fed. Reg. 30190, 30225-30226 (May 23, 2008)) and that the revised regulation is applicable to this case. Specifically, § 405.1869(a) appears to limit the Board's discretionary authority under § 1395oo(d) to specific matters over which the Board has jurisdiction under § 1395oo(a) or (b) ***and*** which are *timely* raised either in the hearing request or a request to add issues to an otherwise properly pending appeal. However, the Board need not resolve this conflict because the facts associated with the unclaimed additional crossover bad debts at issue are similar to those in *SVHHC* and, as discussed in *SVHHC*, the Board has consistently declined to exercise discretion under 42 U.S.C. § 1395oo(d) to hear appeal of other issues involving unclaimed costs when reimbursement of those was not precluded by a specific law, regulation, CMS Ruling or manual instruction and has dismissed those appeals when the sole issue(s) in the case involves unclaimed costs. *See supra* note 7. Accordingly, the Board declines to exercise its discretion under 42 U.S.C. § 1395oo(d) to hear this issue as it relates to the unclaimed additional crossover bad debts at issue to the extent the Board is not barred from exercising that discretion pursuant to 42 C.F.R. § 405.1869(a).

[9] (Emphasis added.)

[10] (Emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

J.C. Ravindran
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Arcadia, CA 91006

RE: ***Jurisdictional Decision***
Carolinas Medical Center - University
Provider No.: 34-0166
FYE: 12/31/2012
PRRB Case No.: 16-0707

Dear Mr. Ravindran,

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

Pertinent Facts:

Carolinas Medical Center – University submitted a request for hearing on January 15, 2016 from a Notice of Program Reimbursement ("NPR") dated July 22, 2015. The hearing request included the following issues:

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

On September 14, 2016, the Provider transferred issues 2, 3, 4, 6, 7, and 8 to group appeals. Issue 2, DSH SSI Percentage (Systemic Errors), was transferred to PRRB Case No. 15-3319GC – QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group. After transfers, Issues 1 and 5 are the sole remaining issues.

The Medicare Contractor submitted a jurisdictional challenge on Issue 1 on May 21, 2018. The Provider submitted a responsive brief on June 14, 2018.

In its appeal request, the Provider summarizes Issue 1, the 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 the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations.
>
> The Provider contends that its' [sic] SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> The Provider contends that the SSI percentage issued by CMS and the subsequent audit adjustment to the Provider's cost report by the MAC are both flawed.
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period. *See* 42 U.S.C. 1395 (d)(5)(F)(i).[1]

Similarly, the Provider describes Issue 2, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 15-3319GC, as follows:

> The Provider contends that the MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute at 42 U.S.C. § 1395ww(d)(5)(F)(i). The Provider further contends that the SSI percentages calculated by [CMS] and used by the MAC to settle their Cost Report does not address all the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, *as amended*, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporates a new methodology inconsistent with the Medicare statute.
>
> The Providers challenge their SSI percentages based on the following reasons:

[1] Individual Appeal Request, Issue 1 Issue Statement.

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.[2]

The Provider submitted its Final Position Paper on May 17, 2022. It did not address Issue 2 in its Final Position Paper.

Medicare Contractor's Contentions

The Medicare Contractor contends Issue 1 should be dismissed from this case. According to the Provider's appeal request, Issue 1 has two components: 1) SSI data accuracy and 2) SSI realignment. As noted above, the Provider transferred Issue 2 to Group Case No. 15-3319GC, "*QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group*." The Medicare Contractor contends that the portion of Issue 1 related to SSI data accuracy should be dismissed because it is duplicative of the issue under appeal in Group Case No. 15-3319GC.[3]

The Medicare Contractor also contends that the portion of Issue 1 related to SSI realignment should also be dismissed. The Medicare Contractor contends that since the Provider has not decided whether to request realignment, the appeal issue is premature. Additionally, the Medicare Contractor considers the SSI realignment issue to be abandoned since the Provider did not brief the issue in its preliminary position paper.[4]

Provider's Contentions

The Provider contends that each of the appealed SSI issues are separate and distinct issues, and that the Board should find jurisdiction over PRRB Case Number 16-0707.

The Provider contends that Board Rule 8.1 states "Some issues may have multiple components. To comply with the regularity requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible…" Appeal issues #1 and #2 represent different components of the SSI issue, which was specifically adjusted during the audit. Since these specific appeal issues represent different aspects/components of the SSI issue, the Provider contends the Board should find jurisdiction over both the SSI Systemic and SSI Provider Specific/Realignment issues.[5]

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[2] Individual Appeal Request, Issue 2 Issue Statement.
[3] Medicare Contractor's jurisdictional challenge at 4.
[4] Medicare Contractor's jurisdictional challenge at 6.
[5] Provider's jurisdictional response at 1.

The Provider asserts that the SSI Systemic issue addresses the various errors discussed in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008) in CMS' calculation of the disproportionate payment percentage, which result in the MedPAR not reflecting all individuals who are eligible for SSI. These systemic errors are the results of CMS's improper policies and data matching process. With respect to the SSI Provider Specific issue, the Provider asserts it is not addressing the errors which result from CMS's improper data matching process, but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. The Provider has specifically identified patients believed to be entitled to both Medicare Part A and SSI who were not included in the SSI percentage determined by CMS, due to errors that are or may be specific to the Provider, but in any case, are not the systemic errors that have been previously identified in the *Baystate* litigation. Once these patients are identified, the Provider contends that it will be entitled to a correction of these errors of omission to its SSI percentage.[6]

Board Decision:

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

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

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

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

A. *First Aspect of Issue 1*

The Board finds that the first aspect of Issue 1- the Provider's disagreement with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage - is duplicative of the DSH SSI Percentage (Systemic Errors) issue transferred to Group Case No. 15-3319GC, "*QRS Carolinas HealthCare 2012 DSH SSI Percentage CIRP Group*. The first aspect of Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[7] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[8] Similarly, the Provider argues that "it[s] SSI percentage

[6] Provider's jurisdictional response at 2-3.
[7] Individual Appeal Request, Issue 1.
[8] Individual Appeal Request, Issue 1.

published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[9] Issue 2, transferred to group Case No. 15-3319GC, similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).

Thus, the Board finds that the first aspect of Issue 1 in this appeal is duplicative of Issue 2 transferred to Case No. 15-3319GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (Jul. 1, 2015), the Board dismisses this aspect of the DSH 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 15-3319GC. 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] 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 any 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. 15-3319GC.

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 Issue 2. Accordingly, the Board finds that the Provider's Final Position Paper failed to comply with the Board Rule 25 governing the content of position papers. As explained in the Commentary to Rule 23.3, the Board requires position papers "to be ***fully*** developed and include ***all*** *available* documentation necessary to provide a *thorough understanding* of the parties' positions."[11] Here, it is clear that the Provider failed to *fully* develop the merits of its position on Issue 1 by explaining the nature of any alleged "errors" in its Final Position Paper and including *all* exhibits. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[12] However, the Provider simply states again it is "seeking [MEDPAR 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" but fails to give any update on those efforts since it filed its Final Position Paper on May 17, 2022, in direct violation of Board Rule 25.2.2:

[9] Individual Appeal Request, Issue 1.
[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).
[11] (Emphasis added.)
[12] (Emphasis added.)

> 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.

Accordingly, the Board finds that Issue 1 and Issue 2, which was transferred to Group Case No. 15-3319GC, 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 Percentage (Provider Specific) issue. In the alternative, the Board dismisses Issue 1 due to the Provider's failure to properly brief the issue in its Final Position Paper in compliance with Board Rules.

B. Second Aspect of Issue 1

The Board finds that the Provider abandoned the SSI realignment portion of Issue 1 as it did not brief the issue in its final position paper.

Board Rule 27 addresses final position papers. Specifically, the content of final position papers is addressed at 27.2:

> The final position paper should address **each issue remaining in the appeal**. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.[13]

Board Rule 25.3 Filing Requirements to Board states the following:

> If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issued abandoned and effectively withdrawn.

As the Provider abandoned the SSI realignment portion of Issue in its final position paper, the Board dismisses the SSI realignment portion of Issue 1 from the appeal.

Conclusion:

The Board dismisses Issue 1, the DSH SSI Percentage (Provider Specific) issue, in its entirety from this appeal. The case remains open given that another issue, DSH Medicaid Eligible Days, remains pending.

---

[13] (Emphasis added.)

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

<u>Board Members Participating</u>:

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Ratina Kelly, CPA

For the Board:

6/6/2022

X Kevin D. Smith, CPA

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Board Member
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cc: Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
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DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Clovis Community Medical Center (Prov. No. 05-0492)
FYE 8/31/2008
Case No. 13-2578

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Clovis Community Medical Center's ("Provider") Individual Appeal Request on appeal on August 14, 2013, appealing from a Notice of Program Reimbursement ("NPR") dated February 20, 2013 for fiscal year ending August 31, 2008. The decision of the Board is set forth below.

Effect of COVID -19 on Board Operations:

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 remains in effect.

Procedural history:

The initial appeal contained the three (3) following issues:

1. DSH Adjustment: Medi-Cal Percentage – Medi-Cal Eligible Days: Partially Paid and Unpaid State Cost 1, 2 and 3 Days (Including Med-Cal HMO Days)
2. I/P Part A and O/P Part B Bad Debt Share of Costs (SOC)
3. DSH: Realignment of the Provider's SSI Percentage

On March 9, 2015 the Board received a new appeal from its Revised NPR ("RNPR") issued September 8, 2014. The RNPR appeal listed the following one (1) additional issue:

4. DSH Adjustment: Medi-Cal Percentage – Medi-Cal Eligible Days: Patients Identified with Medi-Cal Coverage Without State Aid Codes

The Provider withdrew Issue 1 on July 10, 2014 and Issues 2 and 4 on February 28, 2022. As a result, the ***sole*** remaining issue in this case is Issue 3: DSH Realignment.

The DSH Realignment issue was outlined in the initial appeal request as follows:

> **STATEMENT OF ISSUE:** The Intermediary notified the Provider of its SSI percentage as determined by CMS per their web site for FFY 2007, however there was not an adjustment made by the Intermediary to adjust the as filed SSI percentage. Per the provider's letter dated March 20, 2012 (per P-10) to Aryn M. Linnane, Intermediary, a request was made to realign the Provider's SSI to the hospital's FYE August 31, 2008 fiscal year end. The MAC responded per letter dated May 14, 2012 to the Provider per P-11), and sent a letter to CMS, (see P-12) requesting review of Provider's request for it's' [*sic*] recalculation of the SSI percentage for the DSH calculation. No action has been taken on this issue by the MAC at this time.
>
> The provider contends that the SSI should be revised after the realignment is completed.

On October 29, 2021, a Notice of Hearing ("NOH") was issued which set a filing deadline for Provider's Final Position Paper on March 15, 2022 and a hearing for June 13, 2022. ***The NOH was exempt from Alert 19***. A letter from the Board dated October 27, 2021 preceded this NOH explaining that the case had been postponed several times in reliance on Alert 19, and specifically said "the Provider may no longer rely on Alert 19 with respect to filing deadlines in the new Notice of Hearing and failure of the Provider to respond to these filing deadlines (as set forth in that new Notice of Hearing) may result in the dismissal of this case." Furthermore, the letter noted that any subsequent requests for postponement "***must*** *include* a description of the parties' efforts to resolve the case (including dates and times)."

On March 2, 2022 the Provider submitted an "Update re Status and Joint Request for Postponement of Hearing." The request seeks a one-year extension of the hearing date. With regard to this case, it states that it requested a realignment in 2012, which the Medicare acknowledged and forwarded to CMS. The Provider notes that it has corresponded with the Medicare Contractor numerous times in the last year, most recently in late February, 2022, but that the Medicare Contractor indicated it has received no updates from CMS on the request for realignment. The Provider requests a one-year extension of the hearing date in the hopes of resolving this issue administratively. To date, the Provider has not filed its Final Position Paper.

Board Decision:

SSI Realignment

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835-405.1840, a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

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

The Board concludes that it does not have jurisdiction over the SSI Realignment issue in the appeal because there is no final determination from which the Provider is appealing, and dismiss the issue from the appeal. Under 42 C.F.R. § 412.106(b)(3) a hospital can, if it prefers, use its cost reporting period data instead of the federal fiscal year data in determining the DSH Medicare fraction. The decision to use its own cost reporting period is the hospital's alone, which then must submit a written request to the Medicare Contractor.

The Provider here states that it did submit a request to the Medicare Contractor for a realignment, but there has still been no final determination issued for the Provider to appeal for this issue. Accordingly, there is no final determination at issue for the Provider to appeal and, as such, no appeal rights afforded under 42 C.F.R. § 405.1835(a).

Failure to File its Position Paper and Insufficient Postponement Request

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

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

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

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board appeal to comply with Board rules and orders or for inappropriate conduct during proceedings in the appeal.
> (b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may—

> (1) Dismiss the appeal with prejudice;
> (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.

Similarly, the Board's Rules (August 29, 2018) further emphasize the need for the parties to meet filing deadlines. Rule 23.1 states, in pertinent part:

> To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:
>
> - Jointly agree to a proposed Joint Scheduling Order (JSO) . . . or,
> - If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.
>
> **Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.**[1]

Rule 23.3 is accompanied with a heading that reads "Preliminary Position Papers Required if no Proposed JSO is Executed"[2] and explains:

> If the parties do not jointly execute and file a proposed JSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

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

> The Provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, **the case will be dismissed**.[3] If the Intermediary fails to timely file a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.

[1] Emphasis in original.
[2] The requirements for Final Position Papers are generally the same as those for preliminary position papers. *See* Board Rule 27.2 (2018).
[3] Emphasis added.

Rule 23.5 related to extension requests for Preliminary Position Papers and the associated commentary states that an extension **must** be filed at least three weeks before the due date and will only be granted for good cause.

As previously noted, the October 29, 2021 NOH ***specifically*** noted that the filing deadlines therein were exempt from Alert 19's suspension of Board-set deadlines. This NOH was preceded by a Board letter dated October 27, 2021 which specifically said "the Provider may no longer rely on Alert 19 with respect to filing deadlines in the new Notice of Hearing and failure of the Provider to respond to these filing deadlines (as set forth in that new Notice of Hearing) may result in the dismissal of this case. Nevertheless, the Provider did not file its Final Position Paper by the deadline set forth in the NOH, and has still not made such a filing at the time of this decision's issuance. While the Provider did request an extension of time for its Final Position Paper, the Board had not yet ruled on the request prior to the deadline.[4] As a result, the Board finds the Provider's failure to comply with the Board's Rules, specifically the filing deadlines noted for the Provider's Final Position Paper, as an alternative basis for dismissal of this case in its entirety.

Conclusion

The Board finds that it lacks jurisdiction over Issue 3 (DSH: Realignment of the Provider's SSI Percentage) because it is a hospital's election and there is no final determination from which to appeal. Since this is the last remaining issue in the case, the Board hereby closes the case and removes it from its docket. The Board notes that an alternative basis for dismissal lies in the Provider's failure to comply with the Board's Rules, specifically the filing deadlines noted for the Provider's Final Position Paper.

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

For the Board:

6/7/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)

[4] *See* Board Rule 30.3.2 (Nov. 2021) ("NOTE: A motion for postponement pending before the Board that has not yet been completed or ruled upon will not suspend either the hearing date or any pre-hearing filing deadlines (*e.g.*, position papers, witness lists). If a motion for postponement is not complete or has not been ruled on, the parties must proceed as if it will not occur (or will not be granted) and comply with the hearing date and all filing deadlines.").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Decision***
Clovis Community Medical Center (Prov. No. 05-0492)
FYE 8/31/2009
Case No. 13-3688

Dear Ms. Marsden:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Clovis Community Medical Center's ("Provider") Individual Appeal Request on appeal on September 13, 2013, appealing from a Notice of Program Reimbursement ("NPR") dated March 27, 2013 (and revised NPR dated March 16, 2015) for fiscal year ending August 31, 2009. The decision of the Board is set forth below.

Effect of COVID -19 on Board Operations:

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. In particular, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward. Board Alert 19 remains in effect.

Procedural history:

The initial appeal contained the two (2) following issues:

1. DSH Adjustment: Medi-Cal Percentage – Medi-Cal Eligible Days: Partially Paid and Unpaid State Cost 1 and 3 Days (Including Med-Cal HMO Days)
2. I/P Part A and O/P Part B Bad Debt Share of Costs (SOC)

On August 31, 2015 the Board received a new appeal from its Revised NPR ("RNPR") issued March 16, 2015. The RNPR appeal listed the following five (5) additional issues:

3. DSH Adjustment: Medi-Cal Percentage – Medi-Cal Eligible Days: Patients Identified with Medi-Cal Coverage Without State Aid Codes

4. DSH Adjustment – Medi-Cal Percentage – Medi-Cal Eligible Days – State Eligibility Status Code 2 Days
5. DSH Adjustment – Medi-Cal Percentage – Medi-Cal Eligible Days – State Eligibility Status Code 3 Days
6. DSH Adjustment – Observation Medi-Cal Days in the Numerator
7. DSH Adjustment – SSI Fraction Calculation of Numerator

Issues 3, 4, and 5 were withdrawn by the Provider on July 15, 2020. Issue 1 was withdrawn on August 24, 2020. Issue 7 was withdrawn on June 1, 2021. Issue 2 was withdrawn on October 22, 2021. As a result, Issue 6 (Observation Medi-Cal Days in Numerator) is the ***sole*** remaining issue in the case.

On June 8, 2018, the Board received a Jurisdictional Challenge over the Observation Days Issue (Issue 6). It claims that the Provider's position on this issue is that Observation Days were included in Total Days for the DSH calculation, but Medi-Cal days were not. It also claims that the cited audit adjustments were to remove non-allowable Medicaid cays and to update the allowable DSH percentage based on changes in Medicaid days. The Medicare Contractor concludes that neither of these adjustments address Observation Days, and thus with no specific adjustment, the Board lacks jurisdiction over the issue in an appeal from a RNPR.

The Provider filed a response on July 5, 2018. It argues that the Medicare Contractor failed to satisfy its regulatory requirement to audit completely an accurately, and that it *should have* adjusted the Provider's Medicaid eligible observation days because an adjustment was established for that purpose and the Medicare Contractor determined and included the Provider's (admitted) observation days in the total days (82 days) in the denominator of the Medicaid fraction, but failed to include the Medicaid eligible admitted observation days (15 days) in the numerator of the Medicaid fraction. The Provider believes that the Medicare Contractor had an obligation to identify which of the 82 observation days in the denominator were also Medicaid eligible to be included in the numerator.

The Provider concedes and "acknowledges that the [Medicare Contractor] did not specifically remove observation days from the numerator of the Medicaid fraction," but argues it can still appeal these disputed days since the Medicare Contractor added 82 observation days to the denominator of the Medicaid fraction.[1] The Provider claims that it was the Medicare Contractor's own error in adding observation days to the "total days" in the denominator, but failing to make a similar corrective adjustment to the numerator to add any Medicaid eligible observation days to the numerator. The Provider argues that the Medicare Contractor has an obligation to audit a cost report to assure accuracy and a correct settlement, and that this corrective adjustment to the numerator should have been obvious.

The Provider concludes with a discussion of *Bethesda Hospital Association v. Bowen*,[2] arguing that it was not required to present this particular issue to the Medicare Contractor as a

[1] Provider's Response to Medicare Administrative Contractor's Jurisdictional Challenge, 3 (July 5, 2018).
[2] 108 S. Ct. 1255 (1988).

prerequisite to a Board hearing. It also argues that the Board may exercise its discretion over this issue pursuant to 42 U.S.C. 1395oo(d).

On October 29, 2021, a Notice of Hearing ("NOH") was issued which set a filing deadline for Provider's Final Position Paper on March 15, 2022 and a hearing for June 13, 2022. ***The Board specifically exempted the deadlines and hearing in NOH from Alert 19***. A letter from the Board dated October 27, 2021 preceded this NOH explaining that the case had been postponed several times in reliance on Alert 19, and specifically said "the Provider may *no longer* rely on Alert 19 with respect to filing deadlines in the new Notice of Hearing and failure of the Provider to respond to these filing deadlines (as set forth in that new Notice of Hearing) may result in the dismissal of this case." Furthermore, the letter noted that any subsequent requests for postponement "***must*** *include* a description of the parties' efforts to resolve the case (including dates and times)."

On March 2, 2022 the Provider submitted an "Update re Status and Joint Request for Postponement of Hearing." The request seeks a one-year extension of the hearing date. With regard to this case, it states that the Board has not yet issued a ruling on the pending jurisdictional challenge, and the Provider is awaiting a ruling "to inform its decision on how to move forward with the appeal." To date, the Provider has not filed its Final Position Paper.

Board Decision:

RNPR Appeal

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2015), which provides in relevant part:

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

Additionally, 42 C.F.R. § 405.1889 (2015)[3] 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.

[3] *See also Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Services of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

> (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.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] In this case, the number of observation days that were adjusted related to the "total days" in the *denominator* of the Medicaid fraction. The Provider concedes that the number of Medicaid eligible days in the ***numerator*** of the Medicaid fraction were not specifically revised.[5] Based on the foregoing, the Board finds that it lacks jurisdiction over this issue because there was no adjustment to the Medicaid fraction address or relating to Observation Days but rather the adjustments made in the RNPR were to remove certain non-allowable Medicaid days.

Failure to File its Position Paper and Insufficient Postponement Request

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

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

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

> (a) The Board has full power and authority to make rules and establish procedures, not inconsistent with the law, regulations, and CMS Rulings, that are necessary or appropriate to carry out the provisions of section 1878 of the Act and of the regulations in this subpart. The Board's powers include the authority to take appropriate actions in response to the failure of a party to a Board

[4] 42 C.F.R. § 405.1889(b)(1).
[5] Provider's Response to Medicare Administrative Contractor's Jurisdictional Challenge, 3 (July 5, 2018).

> 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.

Similarly, the Board's Rules (August 29, 2018) further emphasize the need for the parties to meet filing deadlines. Rule 23.1 states, in pertinent part:

> To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:
> - Jointly agree to a proposed Joint Scheduling Order (JSO) . . . or,
> - If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.
>
> **Upon receiving an appeal request, the Board will send an acknowledgement establishing the first filing due date. By that date, the parties must take one of the options.**[6]

Rule 23.3 is accompanied with a heading that reads "Preliminary Position Papers Required if no Proposed JSO is Executed"[7] and explains:

> If the parties do not jointly execute and file a proposed JSO by the due date, the position paper deadlines established in the acknowledgement letter will control. Both parties must file preliminary position papers that comply with Rule 25 (and exchange documentation) by their respective due dates.

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

> The Provider's preliminary position paper due date will be set on the same day as the PJSO due date; accordingly, if neither a PJSO nor the provider's preliminary position paper is filed by such date, **the case will be dismissed.**[8] If the Intermediary fails to timely file

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[6] Emphasis in original.
[7] The requirements for Final Position Papers are generally the same as those for preliminary position papers. *See* Board Rule 27.2 (2018).
[8] Emphasis added.

> a responsive preliminary position paper by its due date, the Board will take the actions described under 42 C.F.R. § 405.1868.

Rule 23.5 related to extension requests for Preliminary Position Papers and the associated commentary states that an extension **must** be filed at least three weeks before the due date and will only be granted for good cause.

As previously noted, the October 29, 2021 NOH ***specifically*** noted that the filing deadlines therein were exempt from Alert 19's suspension of Board-set deadlines. This NOH was preceded by a Board letter dated October 27, 2021 which specifically said "the Provider may no longer rely on Alert 19 with respect to filing deadlines in the new Notice of Hearing and failure of the Provider to respond to these filing deadlines (as set forth in that new Notice of Hearing) may result in the dismissal of this case. Nevertheless, the Provider did not file its Final Position Paper by the deadline set forth in the NOH, and has still not made such a filing at the time of this decision's issuance. In October 27 letter, the Board specifically noted that any request to postpone the filing deadlines "***must*** *include* a description of the parties' efforts to resolve the case (including dates and times)." The most recent postponement request filed simply stated the Provider is waiting on a decision on the Jurisdictional Challenge, but provides no indication of any efforts made to resolve the remaining issue. The Board finds the request for postponement to be deficient and thereby ***denies*** the request. As a result, the Board finds the Provider's failure to comply with the Board's Rules, specifically the filing deadlines noted for the Provider's Final Position Paper, as an alternative basis for dismissal of this case in its entirety.

Conclusion

The Board finds that it lacks jurisdiction over Issue 6 (DSH Adjustment – Observation Medi-Cal Days in the Numerator) because it was not specifically revised in the RNPR which is the basis for the appeal. Since this is the last remaining issue in the case, the Board hereby closes the case and removes it from its docket. The Board notes that an alternative basis for dismissal lies in the Provider's failure to comply with the Board's Rules, specifically the filing deadlines noted for the Provider's Final Position Paper.

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

Board Members:

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For the Board:

6/7/2022

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RE: ***EJR Determination***
Case No. 20-0450GC: *Cleveland Clinic Health CY 2017 DGME Fellow Present Year CIRP Group*
Case No. 20-0451GC: *Cleveland Clinic Health CY 2017 DGME Fellow Penalty Prior and Penultimate Years CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 9, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Provider's group issue statements describe the DGME Penalty issue as follows:

> Under CMS's current methodology for calculating payments for direct graduate medical education ("DGME"), a hospital is penalized if in a given year it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are "fellows" (*i.e.,* residents who are not in their initial residency period). For each additional fellow that a hospital trains in excess of its unweighted FTE cap, its *total* DGME payment is reduced.
>
> The Providers are appealing the effect of this policy on the calculation of the FTEs for the present year, prior year and penultimate year.
>
> The origin of the "fellow penalty" stems from the interplay of two provisions of the Medicare statute governing how FTEs are counted for DGME purposes. One provision of the statute, Social Security Act ("Act") Section 1886(h)94)(C), states that FTEs attributable to fellows are assigned a "weighting factor" of 0.5, and FTEs attributable to residents in their initial residency period ("IRP residents") are weighted at 1.00. These weighting factors are applied to calculate a hospital's weighted FTE count. The other provision at issue, Act Section 1886(h)(4)(F)(i), places a cap on the number of unweighted FTEs that a hospital can count in a

given year by the number reported in its most recent cost reporting period ending on or before December 31, 1996.

The Providers challenge the application of CMS's regulatory formula at 42 C.F.R. § 413.79(c)(2)(iii) insofar as it was used to calculate the Providers' cap-adjusted weighted FTE counts for the present , prior and penultimate years.[1]

Background

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

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

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

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

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

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

---

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

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

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

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated

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

separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

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

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

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

> residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

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

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

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

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

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

<u>The Providers' Position</u>

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. It necessarily yields this result by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). As a result, the hospital's allowable FTE count violates the statutory command requiring the Secretary to weight each resident in their initial residency period at 1.0 and each resident training beyond that period (i.e. , a fellow at 0.5).[17]

The Providers assert that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Provider asserts that the regulation produces absurd results. The Providers explain that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the

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[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] Providers' EJR Request at 10.

regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Providers believe that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.[18]

Moreover, the Providers explain that the hospital's present-year FTE count is carried forward to become its prior-year FTE count in the following year, and the penultimate-year FTE count in the year after that. The Providers assert that the regulation as applied in any year adversely affects reimbursement in subsequent years within the three-year rolling average. For this reason, the Providers are seeking a correction of the allowable FTE counts for its present, prior and penultimate cost reporting years.[19]

The Providers argue that the Board lacks the authority to decide the validity of CMS's regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2)(ii), and lacks the authority to grant the relief requested by the Providers, the Board should grant its request for EJR.[20]

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;[21]
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[18] Providers' EJR Request at 11.
[19] Providers' EJR Request at 10.
[20] Provider's EJR Request at 16.
[21] Pursuant to the final rule in the Federal Register on November 13, 2015 and effective January 1, 2016 for cost reporting periods beginning on or after January 1, 2016,25 the Secretary: "[A]dopt[ed] [her] proposal to eliminate our interpretation (in §§ 405.1835(a)(1) and 405.1840(b)(3)) that a provider must make an appropriate cost report claim for an item in order to meet the dissatisfaction requirement for Board jurisdiction over appeals of a timely final contractor determination or Secretary determination."80 Fed. Reg. 70298, 70571 (Nov. 13, 2015)(emphasis added). As a result, making a specific claim (whether for reimbursement or protest) on the as-filed cost report for the issue being appealed is no longer needed to meet the dissatisfaction requirement for Board jurisdiction over an appeal of that issue.

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [22]

- 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.[23]

In these cases, the Providers timely appealed from NPRs. The claimed amount in controversy in these cases exceeds the $50,000 threshold. The Medicare Contractor has not filed any Substantive Claim Challenge or noted any jurisdictional impediments since the receipt of the initial appeal and the Providers' EJR Request.

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

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

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

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[22] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[23] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[24] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[25] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[26] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[27]

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

B. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[30] As such, the equation would logically appear to be a

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[26] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[27] *See* 42 C.F.R. § 405.1873(a).
[28] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[29] EJR Request at 4.
[30] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[31] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[32]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[33] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[34] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[35] (*i.e.*, ratios) using variables a, b, c, and d:

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[31] 66 Fed. Reg. at 39894 (emphasis added).

[32] (Emphasis added.)

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

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

[35] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and

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

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

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

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

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

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

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

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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:

6/7/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Case No. 21-1333GC: *Beaumont Health CY 2016 DGME Fellow Penalty Present Year CIRP Group*
Case No. 21-1334GC: *Beaumont Health CY 2016 DGME Fellow Penalty Prior and Penultimate Years CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 9, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Provider's group issue statements describe the DGME Penalty issue as follows:

> Under CMS's current methodology for calculating payments for direct graduate medical education ("DGME"), a hospital is penalized if in a given year it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are "fellows" (*i.e.,* residents who are not in their initial residency period). For each additional fellow that a hospital trains in excess of its unweighted FTE cap, its *total* DGME payment is reduced.
>
> The Providers are appealing the effect of this policy on the calculation of the FTEs for the present year, prior year and penultimate year.
>
> The origin of the "fellow penalty" stems from the interplay of two provisions of the Medicare statute governing how FTEs are counted for DGME purposes. One provision of the statute, Social Security Act ("Act") Section 1886(h)94)(C), states that FTEs attributable to fellows are assigned a "weighting factor" of 0.5, and FTEs attributable to residents in their initial residency period ("IRP residents") are weighted at 1.00. These weighting factors are applied to calculate a hospital's weighted FTE count. The other provision at issue, Act Section 1886(h)(4)(F)(i), places a cap on the number of unweighted FTEs that a hospital can count in a

given year by the number reported in its most recent cost reporting period ending on or before December 31, 1996.

The Providers challenge the application of CMS's regulatory formula at 42 C.F.R. § 413.79(c)(2)(iii) insofar as it was used to calculate the Providers' cap-adjusted weighted FTE counts for the present , prior and penultimate years.[1]

Background

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

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

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

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

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

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

---

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

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

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

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated

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

separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

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

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

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

> residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

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

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

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

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

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

<u>The Providers' Position</u>

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. It necessarily yields this result by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). As a result, the hospital's allowable FTE count violates the statutory command requiring the Secretary to weight each resident in their initial residency period at 1.0 and each resident training beyond that period (i.e. , a fellow at 0.5.[17]

The Providers assert that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Providers assert that the regulation produces absurd results. The Providers explain that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the

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[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] Providers' EJR Request at 10.

regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Providers believe that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.[18]

Moreover, the Providers explain that the hospital's present-year FTE count is carried forward to become its prior-year FTE count in the following year, and the penultimate-year FTE count in the year after that. The Providers assert that the regulation as applied in any year adversely affects reimbursement in subsequent years within the three-year rolling average. For this reason, the Providers are seeking a correction of the allowable FTE counts for its present, prior and penultimate cost reporting years.[19]

The Providers argue that the Board lacks the authority to decide the validity of CMS's regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2)(ii), and lacks the authority to grant the relief requested by the Providers, the Board should grant its request for EJR.[20]

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;[21]
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[18] Providers' EJR Request at 11.
[19] Providers' EJR Request at 10.
[20] Providers' EJR request at 16.
[21] Pursuant to the final rule in the Federal Register on November 13, 2015 and effective January 1, 2016 for cost reporting periods beginning on or after January 1, 2016,25 the Secretary: "[A]dopt[ed] [her] proposal to eliminate our interpretation (in §§ 405.1835(a)(1) and 405.1840(b)(3)) that a provider must make an appropriate cost report claim for an item in order to meet the dissatisfaction requirement for Board jurisdiction over appeals of a timely final contractor determination or Secretary determination."80 Fed. Reg. 70298, 70571 (Nov. 13, 2015)(emphasis added). As a result, making a specific claim (whether for reimbursement or protest) on the as-filed cost report for the issue being appealed is no longer needed to meet the dissatisfaction requirement for Board jurisdiction over an appeal of that issue.

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [22]
- 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.[23]

In these cases, the Providers timely appealed from NPRs of the DGME issue and the Board review of the subject matter appealed is not precluded by statute or regulation. The claimed amount in controversy in these cases exceeds the $50,000 threshold. The Medicare Contractor has not filed any jurisdictional impediments since the receipt of the initial appeal and the Providers' EJR Request. Accordingly, the Board finds that it has jurisdiction over the appeal and the participants.

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

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

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

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[22] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[23] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[24] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[25] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[26] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[27]

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

B. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[30] As such, the equation would logically appear to be a

[26] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[27] *See* 42 C.F.R. § 405.1873(a).
[28] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[29] EJR Request at 4.
[30] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[31] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[32]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[33] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[34] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[35] (*i.e.*, ratios) using variables a, b, c, and d:

---

[31] 66 Fed. Reg. at 39894 (emphasis added).
[32] (Emphasis added.)
[33] *See* 62 Fed. Reg. at 46005 (emphasis added).
[34] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[35] Two alternative ways to express the algebraic principle of equivalent functions include:
If $a/b = c/d$, then $c = (a \times d) / b$; and

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

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

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

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

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

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

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

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

6/7/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-8)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Case No. 22-1020GC: *Mount Sinai Health System CY 2017 DGME Fellow Penalty Prior and Penultimate Years CIRP Group*
Case No. 22-1021GC: *Mount Sinai Health System CY 2017 DGME Fellow Penalty Present Year CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 9, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Provider's group issue statements describe the DGME Penalty issue as follows:

> Under CMS's current methodology for calculating payments for direct graduate medical education ("DGME"), a hospital is penalized if in a given year it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are "fellows" (*i.e.,* residents who are not in their initial residency period). For each additional fellow that a hospital trains in excess of its unweighted FTE cap, its *total* DGME payment is reduced.
>
> The Providers are appealing the effect of this policy on the calculation of the FTEs for the present year, prior year and penultimate year.
>
> The origin of the "fellow penalty" stems from the interplay of two provisions of the Medicare statute governing how FTEs are counted for DGME purposes. One provision of the statute, Social Security Act ("Act") Section 1886(h)94)(C), states that FTEs attributable to fellows are assigned a "weighting factor" of 0.5, and FTEs attributable to residents in their initial residency period ("IRP residents") are weighted at 1.00. These weighting factors are applied to calculate a hospital's weighted FTE count. The other provision at issue, Act Section 1886(h)(4)(F)(i), places a cap on the number of unweighted FTEs that a hospital can count in a

given year by the number reported in its most recent cost reporting period ending on or before December 31, 1996.

The Providers challenge the application of CMS's regulatory formula at 42 C.F.R. § 413.79(c)(2)(iii) insofar as it was used to calculate the Providers' cap-adjusted weighted FTE counts for the present , prior and penultimate years.[1]

Background

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

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

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

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

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

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

---

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

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

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

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated

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

separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

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

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

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

> residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

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

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

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

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

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

<u>The Providers' Position</u>

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. It necessarily yields this result by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). As a result, the hospital's allowable FTE count violates the statutory command requiring the Secretary to weight each resident in their initial residency period at 1.0 and each resident training beyond that period (i.e. , a fellow at 0.5).[17]

The Providers assert that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Providers assert that the regulation produces absurd results. The Providers explain that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the

[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] Providers' EJR Request at 10.

regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Provider believe that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.[18]

Moreover, the Providers explain that the hospital's present-year FTE count is carried forward to become its prior-year FTE count in the following year, and the penultimate-year FTE count in the year after that. The Providers assert that the regulation as applied in any year adversely affects reimbursement in subsequent years within the three-year rolling average. For this reason, the Providers are seeking a correction of the allowable FTE counts for its present, prior and penultimate cost reporting years.[19]

The Providers argue that the Board lacks the authority to decide the validity of CMS's regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2)(ii), and lacks the authority to grant the relief requested by the Providers, the Board should grant its request for EJR.[20]

<u>Decision of the Board</u>

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;[21]
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[18] Providers' EJR Request at 11.
[19] Providers' EJR Request at 10.
[20] Provider's EJR Request at 16.
[21] Pursuant to the final rule in the Federal Register on November 13, 2015 and effective January 1, 2016 for cost reporting periods beginning on or after January 1, 2016,25 the Secretary: "[A]dopt[ed] [her] proposal to eliminate our interpretation (in §§ 405.1835(a)(1) and 405.1840(b)(3)) that a provider must make an appropriate cost report claim for an item in order to meet the dissatisfaction requirement for Board jurisdiction over appeals of a timely final contractor determination or Secretary determination."80 Fed. Reg. 70298, 70571 (Nov. 13, 2015)(emphasis added). As a result, making a specific claim (whether for reimbursement or protest) on the as-filed cost report for the issue being appealed is no longer needed to meet the dissatisfaction requirement for Board jurisdiction over an appeal of that issue.

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [22]

- 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.[23]

In these cases, the Providers timely appealed from NPRs of the DGME issue and the Board review of the subject matter appealed is not precluded by statute or regulation. The claimed amount in controversy in these cases exceeds the $50,000 threshold. The Medicare Contractor has not filed any jurisdictional impediments since the receipt of the initial appeal and the Providers' EJR Request. Accordingly, the Board finds that it has jurisdiction over the appeal and the participants.

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

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

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

[22] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[23] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[24] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[25] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[26] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[27]

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

B. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[30] As such, the equation would logically appear to be a

[26] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[27] *See* 42 C.F.R. § 405.1873(a).
[28] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[29] EJR Request at 4.
[30] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[31] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[32]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[33] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[34] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[35] (*i.e.*, ratios) using variables a, b, c, and d:

[31] 66 Fed. Reg. at 39894 (emphasis added).
[32] (Emphasis added.)
[33] *See* 62 Fed. Reg. at 46005 (emphasis added).
[34] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately*…." (Emphasis added.)).
[35] Two alternative ways to express the algebraic principle of equivalent functions include:
If $a/b = c/d$, then $c = (a \times d) / b$; and

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

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

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

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

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

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

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

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

Board Members Participating:

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

FOR THE BOARD:

6/7/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
Case No. 22-1022GC: *Mount Sinai Health System CY 2016 DGME Fellow Penalty Present Year CIRP Group*
Case No. 22-1023GC: *Mount Sinai Health System CY 2016 DGME Fellow Penalty Prior and Penultimate Years CIRP Group*

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 9, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Provider's group issue statements describe the DGME Penalty issue as follows:

> Under CMS's current methodology for calculating payments for direct graduate medical education ("DGME"), a hospital is penalized if in a given year it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are "fellows" (*i.e.,* residents who are not in their initial residency period). For each additional fellow that a hospital trains in excess of its unweighted FTE cap, its *total* DGME payment is reduced.
>
> The Providers are appealing the effect of this policy on the calculation of the FTEs for the present year, prior year and penultimate year.
>
> The origin of the "fellow penalty" stems from the interplay of two provisions of the Medicare statute governing how FTEs are counted for DGME purposes. One provision of the statute, Social Security Act ("Act") Section 1886(h)94)(C), states that FTEs attributable to fellows are assigned a "weighting factor" of 0.5, and FTEs attributable to residents in their initial residency period ("IRP residents") are weighted at 1.00. These weighting factors are applied to calculate a hospital's weighted FTE count. The other provision at issue, Act Section 1886(h)(4)(F)(i), places a cap on the number of unweighted FTEs that a hospital can count in a

given year by the number reported in its most recent cost reporting period ending on or before December 31, 1996.

The Providers challenge the application of CMS's regulatory formula at 42 C.F.R. § 413.79(c)(2)(iii) insofar as it was used to calculate the Providers' cap-adjusted weighted FTE counts for the present , prior and penultimate years.[1]

Background

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

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

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

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

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

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

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

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

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

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

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

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

[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> *To address situations in which a hospital increases the number of FTE residents **over** the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 1998 cost reporting period (that is, of the 110 unweighted residents, 20 are beyond the initial residency period and are weighted as 0.5 FTE), the hospital's weighted FTE count for determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional** reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[11] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated

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

separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

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

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

---

[12] *Id.* at 39894 (emphasis added).

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

> residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996.[14]

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

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

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

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

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

<u>The Providers' Position</u>

The Providers contend that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is unlawful because it further reduces a hospital's weighted FTE count in cases in which a hospital trains residents (whether IRPs or fellows) above the FTE cap. It necessarily yields this result by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the number of unweighted FTEs the hospital reported in that cost reporting year (denominator). As a result, the hospital's allowable FTE count violates the statutory command requiring the Secretary to weight each resident in their initial residency period at 1.0 and each resident training beyond that period (i.e. , a fellow at 0.5.[17]

The Providers assert that the regulation for calculating allowable FTEs in 42 C.F.R. § 413.79(c)(2)(iii) has no basis in the text of the statute that it purports to interpret. Moreover, the Provider asserts that the regulation produces absurd results. The Providers explain that, if a hospital is training residents in excess of its cap, and some of its residents are fellows, under the

[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.
[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] Providers' EJR Request at 10.

regulation, each fellow that the hospital reports in excess of its cap will actually reduce its DGME reimbursement, otherwise known as "the fellow penalty." For these reasons, the Providers believe that the regulation is arbitrary and capricious, in excess of its statutory authority and should be held unlawful.[18]

Moreover, the Providers explain that the hospital's present-year FTE count is carried forward to become its prior-year FTE count in the following year, and the penultimate-year FTE count in the year after that. The Providers assert that the regulation as applied in any year adversely affects reimbursement in subsequent years within the three-year rolling average. For this reason, the Providers are seeking a correction of the allowable FTE counts for its present, prior and penultimate cost reporting years.[19]

The Providers argue that the Board lacks the authority to decide the validity of CMS's regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2)(ii), and lacks the authority to grant the relief requested by the Providers, the Board should grant its request for EJR.[20]

Decision of the Board

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

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

- They are dissatisfied with final determinations of the Medicare Contractor;[21]
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to

[18] Providers' EJR Request at 11.
[19] Providers' EJR Request at 10.
[20] Provider's EJR Request at 16.
[21] Pursuant to the final rule in the Federal Register on November 13, 2015 and effective January 1, 2016 for cost reporting periods beginning on or after January 1, 2016,25 the Secretary: "[A]dopt[ed] [her] proposal to eliminate our interpretation (in §§ 405.1835(a)(1) and 405.1840(b)(3)) that a provider must make an appropriate cost report claim for an item in order to meet the dissatisfaction requirement for Board jurisdiction over appeals of a timely final contractor determination or Secretary determination."80 Fed. Reg. 70298, 70571 (Nov. 13, 2015)(emphasis added). As a result, making a specific claim (whether for reimbursement or protest) on the as-filed cost report for the issue being appealed is no longer needed to meet the dissatisfaction requirement for Board jurisdiction over an appeal of that issue.

their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [22]

- 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.[23]

In these cases, the Providers timely appealed from NPRs of the DGME issue and the Board review of the subject matter appealed is not precluded by statute or regulation. The claimed amount in controversy in these cases exceeds the $50,000 threshold. The Medicare Contractor has not filed any jurisdictional impediments since the receipt of the initial appeal and the Providers' EJR Request. Accordingly, the Board finds that it has jurisdiction over the appeal and the participants.

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

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

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

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[22] 42 U.S.C. § 1395oo(a)(1)(A)(i); *see also Washington Hosp. Ctr. v. Bowen*, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[23] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[24] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[25] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[26] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[27]

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

B. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[30] As such, the equation would logically appear to be a

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[26] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[27] *See* 42 C.F.R. § 405.1873(a).
[28] The Board notes that Board Rule 10.2 states: "If the Medicare contractor opposes a provider's expedited judicial review request, . . . its response must be timely filed in accordance with Rules 42, 43, and 44."
[29] EJR Request at 4.
[30] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[31] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[32]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[33] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[34] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[35] (*i.e.*, ratios) using variables a, b, c, and d:

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[31] 66 Fed. Reg. at 39894 (emphasis added).
[32] (Emphasis added.)
[33] *See* 62 Fed. Reg. at 46005 (emphasis added).
[34] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[35] Two alternative ways to express the algebraic principle of equivalent functions include:
If $a/b = c/d$, then $c = (a \times d) / b$; and

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

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

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

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

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

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

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

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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:

6/7/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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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.

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[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]

<u>Procedural Background</u>

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

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[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 <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).
>
> (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 <u>after finding jurisdiction</u> over the matter at issue <u>and</u> 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 <u>before</u> 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 **<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.**[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 <u>emphasize</u> that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a <u>prerequisite</u>*** *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 <u>until the Board has found jurisdiction</u>*** 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.

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[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

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[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

[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.

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

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[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

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[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 <u>not</u> 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)):

[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**
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> 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]

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[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

[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

[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 is 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.
>
> ****
>
> 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

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

Enclosures: List of Groups

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Pamela VanArsdale, NGS
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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

Provider Reimbursement Review Board
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Via Electronic Delivery

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RE: ***EJR Determination***
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

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 12, 2022 request for expedited judicial review ("EJR") in the above-referenced eight (8) common issue related party ("CIRP") group appeals involving Scottsdale/Honor Health.[1] The decision of the Board is set forth below.

Issue in Dispute

For each year at issue, BHCS established two CIRP groups with one CIRP group addressing the "SSI Fraction/Dual Eligible Days" issue and the other addressing the "Medicaid Fraction/Dual Eligible Days" issue.

In their group issue statement for the "SSI Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

[1] The May 12, 2022 consolidated EJR request also included four additional appeals for FY 2011 and 2012, those requests for EJR are being handled under separate cover. Specifically, the Board has not completed its jurisdictional review and is requesting additional information from the Group Representative. As a finding of jurisdiction by the Board is a prerequisite for Board consideration of an EJR request, 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 <u>until</u>*** *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." (Emphasis is added.)

Statement of Issue

Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.

Statement of Legal Basis

The Provider contends that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.

CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).

While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider(s) contend(s) that the terms paid and entitled must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.

It is the Providers' contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.[2]

[2] *E.g.*, Group Issue Statement for Case No. 14-2499GC.

Similarly, in their group issue statement for the "Medicaid Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **<u>Statement of Issue</u>**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> **<u>Statement of Legal Basis</u>**
>
> The Provider contends that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
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> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider(s) contend(s) that the terms paid and entitled must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.

> It is the Provider's contention that these days must be included in the Medicaid percentage.[3]

While the two issue statements are essentially the same, the Board required the formation of two separate groups for each year as there are two legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group for the "SSI Fraction/Dual Eligible Days" issue challenges the inclusion of noncovered Medicare days in the SSI fraction (as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). The Board views the EJR request as a consolidated request encompassing both CIRP groups for each of the years at issue.

Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[6] 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.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] 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."

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[3] *E.g.*, Group Issue Statement for Case 14-2497GC.
[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

The statute, 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 . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[12]

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.[13]

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.[14]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary, reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[15] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid

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[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] 68 Fed. Reg. 27154, 27207 (May 19, 2003).

fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[16]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[17] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[18] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[19]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[20] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[21] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[22]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[23] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[24] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital

[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.* at 27207-27208.
[20] *Id.* at 27207-08.
[21] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[22] 68 Fed. Reg. at 27208.
[23] *Id.*
[24] *Id.*

would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[25]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[26] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[27]
On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[28] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/ providers/hipps/dual.asp*) on July 9, 2004.[29]
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> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator

[25] *Id.*
[26] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[27] *Id.*
[28] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[29] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[30]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[31] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[32] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *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 and SSI, excluding those patients who received only State supplementation . . .[33]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[34]

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[30] *Id.* at 49099 (emphasis added).
[31] *Id.*
[32] *See id.* at 49099, 49246.
[33] (Emphasis added.)
[34] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[35]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[36] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[37]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[38] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[39] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[40] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[41] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

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[35] *Id.*
[36] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days re only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[37] (Citations omitted and emphasis added.)
[38] 317 F. Supp. 3d 168 (D.D.C. 2018).
[39] *Id.* at 172.
[40] *Id.* at 190.
[41] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[42] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[43] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[44] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[45]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[46] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[47] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[48] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[49] and that the regulation is procedurally invalid.[50]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[51] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[52] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[53] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[54] wherein the Ninth

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[42] *See* 2019 WL668282.
[43] 718 F.3d 914 (2013).
[44] 657 F.3d 1 (D.C. Cir. 2011).
[45] 718 F.3d at 920.
[46] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[47] *Id.* at 1141.
[48] *Id.*
[49] *Id.* at 1162.
[50] *Id.* at 1163
[51] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[52] *Id.* at 884.
[53] *Id.* at 884.
[54] 97 F.3d 1261, 1265-66 (9th Cir. 1996).

Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[55] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[56] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[57] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[58] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these no-pay Part A days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Provider's further contend that the unambiguous language of the Medicare Act mandates exclusion of no-pay Part A days from the Medicare fraction. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above). Finally, the Providers contend that the unambiguous language of the Medicare Act mandates inclusion of no-pay Part A days in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible.

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[55] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[56] *Id.* at 886.
[57] *Id.*
[58] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of no-pay Part A days in the Medicare fraction are illegal and that such days must be included in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

Decision of the Board

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

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

All of the participants in the 8 CIRP groups appealed cost reporting periods beginning prior to January 1, 2016. For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[59] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[60]

On August 21, 2008, new regulations governing the Board were effective.[61] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[62] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance

[59] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[60] *Bethesda*, 108 S. Ct. at 1258-59.
[61] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[62] 201 F. Supp. 3d 131 (D.D.C. 2016).

regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[63]

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

B. Jurisdictional Determination

The Board has determined that the Exhausted Part A/Dual Eligible Days issues in each of these CIRP group cases covering CYs 2007, 2008, 2010 and 2013 are governed by the ruling in *Bethesda* or CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[64] The appeals were timely filed and no jurisdictional impediments have been identified for the remaining participants. Based on the above, the Board finds that it has jurisdiction for the above-captioned CIRP group appeals covering CYs 2007, 2008, 2010 and 2013 and the participants therein.

C. Board's Analysis of the Appealed Issue

The 8 CIRP group appeals in these EJR requests involve the 2007 to 2013 cost reporting periods and each FY includes 2 CIRP groups and involve the ***same*** participants. 42 C.F.R. § 405.1867 specifies that "[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* . . . ."[65] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in

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[63] *Id.* at 142.
[64] *See* 42 C.F.R. § 405.1837.
[65] (Emphasis added.)

the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[66] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[67]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[68] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic*

[66] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[67] *Id*. (emphasis added).
[68] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

Health");[69] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[70]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[71] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the numerator of the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the legal argument in the set of CIRP groups for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument in the set of CIRP groups for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the EJR request as a consolidated request involving the two sets of CIRP groups at issue for CYs 2007 to 2013.

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[69] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.
[70] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[71] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater"*).

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject year and that the Providers in these 8 CIRP group appeals are entitled to a hearing before the Board;

2) Based upon the Providers' assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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

4) It is without authority to decide the legal 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,[72] 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[73]) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The appeals are now closed.

Enclosure: Schedules of Providers

<u>Board Members Participating</u>:

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

cc: Bill Tisdale, Novitas Solutions (J-H)
Wilson Leong, FSS

[72] The Board notes that the Provider is located in the Ninth Circuit.
[73] 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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

James Ravindran
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RE: *EJR Determination*
15-2246GC QRS BHCS Post 10/1/2004 DSH Medicaid Dual Eligible Days CIRP
15-2247GC QRS BHCS Post-10/1/2004 DSH Exhausted Part A/Dual Eligible Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 13, 2022 request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals involving Baylor Health Care System ("BHCS"). As explained by letter dated June, 3, 2022, the 30 day period for responding to the EJR request had not yet begun because the Board had not yet completed its jurisdictional review and that the 30-day clock would not begin until the completion of that process because 42 C.F.R. § 405.1837(b)(2) specifies that "the 30-day period for the Board to make a determination [on an EJR request] 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." The Board has completed its jurisdictional review and, set forth below, is its determination on jurisdiction and its decision to deny the EJR request is based the lack of jurisdiction.[1]

I. Issue in Dispute

On December 23, 2008, BHCS established four CIRP groups, two of which were:

09-0540GC QRS BHCS 97-05 DSH Dual Eligible Days CIRP
09-0541GC QRS BHCS 97-05 Exhausted Part A Days CIRP

On April 24, 2015, the Board issued letters in both appeals, bifurcating the appeals into FYE's ending prior to October 1, 2004 and after, as the FYE's prior to October 1, 2001 were subject to remand under CMS Ruling 1498-R. For both cases, 4 Baylor Providers were transferred to the newly created appeals: 15-2246GC QRS BHCS Post 10/1/2004 DSH Medicaid Dual Eligible

[1] While neither FSS or the MAC requested an extension for this appeal, the Board issued an extension/30-day EJR letter, including the above case, which was issued on June 3, 2022. The Board however, has reviewed and made a jurisdictional determination as of today's date, and is issuing the EJR denial on the same date, within the 30-day period.

Days CIRP; and 15-2247GC QRS BHCS Post-10/1/2004 DSH Exhausted Part A/Dual Eligible Days CIRP.

The issue statement for the original group under Case No. 09-0540GC which was later bifurcated and used to form the post 10/1/2004 FYE under Case No. 15-2246GC is:

> **<u>Statement of Issue</u>**
>
> Whether TrailBlazer Health Enterprises, LLC ("Intermediary") properly *excluded* Medicaid Dual Eligible days from the DSH calculation.[2]
>
> **<u>Statement of Legal Basis</u>**
>
> The Provider contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Staturory instructions at 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). Specifically, the Providers disagree with the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's Regulations.
>
> The Providers contend that the Intermediary failed to include all Medi-Medi patient days (patients who are eligible for Medicaid and have paid and/or covered by Medicare) in the Medicare DSH calculation. These days should have been included in the Medicaid percentage of the DSH calculation See 42 CFR 412.106 and Section 1886 (d)(5)(F)(vi)(II) of the Social Security Act.

Similarly, in the group issue statement for the original group under Case No. 09-0541GC which was later bifurcated to form the post 10-1/2004 FY under Case No. 15-2247GC issue is:

> **<u>Statement of Issue</u>**
>
> Whether TrailBlazer Health Enterprises, LLC ("Intermediary") properly *excluded* exhausted Medicare benefits Medicaid Dual Eligible days from the DSH calculation.[3]
>
> **<u>Statement of Legal Basis</u>**
>
> The Provider contends that the Intermediary did not determine Medicare reimbursement for DSH in accordance with the Statutory instructions at 42 U.S.C. 1395ww(d)(5)(F)(vi)(II). Specifically, the Providers disagree with

[2] Providers' Group Appeal Request, at Issue Statement (Apr. 22, 2015), PRRB Case No. 15-2246GC (emphasis added).
[3] Providers' Group Appeal Request, at Issue Statement (Apr. 22, 2015), PRRB Case No. 15-2247GC (emphasis added).

> the calculation of the second computation of the disproportionate patient percentage, the Medicaid days proxy, set forth at 42 C.F.R. 412.106(b)(4) of the Secretary's Regulations.
>
> The Providers contend that the Intermediary failed to include all Medi-Medi patient days for Medicare part A patients, who Medicare Part a Benefits were exhausted, but who were still eligible for Medicaid, in the Medicaid percentage of the DSH calculation See 42 CFR 412.106 and Section 1886 (d)(5)(F)(vi)(II) of the Social Security Act.

The Board notes that the Group Representative failed to include the above group issue statements used to form these groups.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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").[4] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[5]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[6] 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.[7]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[8] 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.[9] The DPP is defined as the sum of two fractions expressed as percentages.[10] 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, 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

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[4] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[5] *Id.*
[6] *See* 42 U.S.C. § 1395ww(d)(5).
[7] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[8] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[9] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[10] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> 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 . . . .[11]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[12]

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.[13]

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.[14]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[15] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[16]

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[11] (Emphasis added.)
[12] 42 C.F.R. § 412.106(b)(2)-(3).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(4).
[15] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[16] *Id.*

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[17] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[18] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[19]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[20] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[21] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[22]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[23] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[24] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[25]

[17] *Id.*
[18] *Id.*
[19] *Id.* at 27207-27208.
[20] *Id.* at 27207-08.
[21] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[22] 68 Fed. Reg. at 27208.
[23] *Id.*
[24] *Id.*
[25] *Id.*

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[26] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[27]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[28] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[29]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the*

[26] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[27] *Id.*
[28] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[29] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (emphasis added).

> *days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[30]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[31] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[32] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *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 and SSI, excluding those patients who received only State supplementation . . .[33]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[34]

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[30] *Id.* at 49099 (emphasis added).
[31] *Id.*
[32] *See id.* at 49099, 49246.
[33] (Emphasis added.)
[34] (Emphasis added.)

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[35]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[36] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[37]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[38] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[39] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[40] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[41] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

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[35] *Id.*
[36] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[37] (Citations omitted and emphasis added.)
[38] 317 F. Supp. 3d 168 (D.D.C. 2018).
[39] *Id.* at 172.
[40] *Id.* at 190.
[41] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[42] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[43] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp. v. Sebelius*,[44] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[45]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[46] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[47] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[48] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[49] and that the regulation is procedurally invalid.[50]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[51] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[52] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[53] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in

[42] *See* 2019 WL 668282.
[43] 718 F.3d 914 (2013).
[44] 657 F.3d 1 (D.C. Cir. 2011).
[45] 718 F.3d at 920.
[46] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[47] *Id.* at 1141.
[48] *Id.*
[49] *Id.* at 1162.
[50] *Id.* at 1163
[51] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[52] *Id.* at 884.
[53] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[54] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[55] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[56] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[57] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[58] Thus, as of the date of this decision, the Secretary's position with respect to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. <u>Providers' Position as Stated in the EJR Request</u>

As represented in the Provider's EJR request, the Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these no-pay Part A days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Provider's further contend that the unambiguous language of the Medicare Act mandates exclusion of no-pay Part A days from the Medicare fraction. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above). Finally, the Providers contend that the unambiguous language of the

[54] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[55] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[56] *Id.* at 886.
[57] *Id.*
[58] *Becerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

Medicare Act mandates inclusion of no-pay Part A days in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible.

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of no-pay Part A days in the Medicare fraction are illegal and that such days must be included in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

IV. <u>Decision of the Board</u>

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

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

All of the participants in the 8 CIRP groups appealed cost reporting periods beginning prior to January 1, 2016. For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[59] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[60]

On August 21, 2008, new regulations governing the Board were effective.[61] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell*

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[59] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[60] *Bethesda*, 108 S. Ct. at 1258-59.
[61] 73 Fed. Reg. 30190, 30240 (May 23, 2008).

("*Banner*").[62] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[63]

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

B. Jurisdictional Determination for Case Nos. 15-2246GC and 15-2247GC

Both Case Nos. 15-2246GC and 15-2247GC, have the same 4 participants listed in the Schedule of Providers ("SoP") and list them in same order. The Board has set forth its jurisdictional determination for each participant for these cases.

#2 Provider 45-0021 – Baylor University Medical System (FYE 6/30/2007)

Although 3 participants in these two CIR groups appealed fiscal year 2005, there is one provider that appealed a different fiscal year – Participant #2, Baylor University Medical Center ("Baylor"), Prov. No. 45-0021, FYE 6/30/2007. In reviewing the documentation for jurisdiction in both CIRP groups, it was noted that the Board had already granted EJR for Bayor for the Dual Eligible days issue for fiscal year 2007, in Case Nos. 13-3896GC, "*QRS BHCS 2007 DSH Medicaid Fraction/Dual Elig Days CIRP Group*," and 13-3938GC, entitled "*QRS BHCS 2007 DSH SSI Fraction/Dual Eligible Days CIRP Group.*" Specifically, EJR was previously requested in Case Nos. 13-3896GC and 13-3938GC on March 4, 2022 and the Board granted EJR on April 13, 2022.[64] Moreover, Baylor FY 2007 was included in the SoP both Case Nos. 13-3896GC and 13-3938GC for which EJR was granted.

Pursuant to 42 C.F.R. § 405.1837(b)(1), hereinafter called the CIRP regulation:

> Two or more providers under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS

[62] 201 F. Supp. 3d 131 (D.D.C. 2016).
[63] *Id.* at 142.
[64] EJR Determination (Apr. 13, 2022), PRRB Case Nos. 13-3896GC, et al.

> 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.[65]

Subsection (e) requires that the group provider provide notice that the group is fully formed and complete.[66] Once the group is certified as complete, restrictions are placed on the ability for additional providers under common ownership:

> 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.[67]

Pursuant to the CIRP regulations at 42 C.F.R. 405.1837(b)(1) and (e), processing of the EJR on the Board's part dictates that the group is considered fully formed; Any additional providers outside of this group would be part of a duplicate case, violating those same CIRP regulations.[68] As Baylor FY 2007 is a participant in PRRB Case Nos. 15-2246GC and 15-2247GC, and was also a participant in Case Nos. 13-3896GC and 13-3938GC for the same issue and for the same fiscal year, this provider within these cases is in violation of 405.1837(b)(1) and (e), and thus must be dismissed.

Furthermore, the Board notes that the EJR requests for which the Board granted EJR (as well as the Board's EJR decision itself) clearly encompassed the ***complete*** Dual Eligible days issue, i.e., where the Board maintained that that the legal argument in the set of CIRP groups for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the legal argument in the set of CIRP groups for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the *subset* of no-pay part A days that involve patients who are also eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board treated the EJR request and decision as a consolidated request involving the two sets of CIRP groups at issue for CYs 2007 to 2013.[69]

As such, the Board dismisses Baylor University Medical Center (45-0021), for FYE 2007, in both cases 15-2246GC and 15-2247GC because the issue was disposed of through the EJR of

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[65] 42 C.F.R. § 405.1837(b)(1).
[66] 42 C.F.R. § 405.1837(e)(1).
[67] *Id*.
[68] *See* 42 C.F.R. § 405.1837(e) ("[w]hen 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.").
[69] EJR Determination, at 19 (Apr. 13, 2022), PRRB Case Nos. 13-3896GC, et al.

Case Nos. 13-3896GC and 13-3938GC, therefore the inclusion of that provider in Case Nos. 15-2246GC and 15-2247GC violates the CIRP regulations at 42 C.F.R. § 405.1837(b)(1) and (e).

#1 Provider 45-0021 – Baylor University Medical System (FYE 6/30/2005)

Baylor's NPR was issued on September13, 2007 for FY 2005. Baylor filed an appeal request for FY 2005 on March 11, 2008 to establish the individual case under Case No. 08-1385. The Group Representative represented on the SoP that the Provider timely filed an add request in Case No. 08-1835 on October 13, 2008[70] in order to add the issues that were later transferred from Case No. 08-1835 to the two CIRP groups. However, the Group Representative failed to include any documentation in the record to establish that the add issue was filed with the Board in Case No. 08-1385 and that that filing was in fact timely. In this regard, the Board notes that, as a result of the revisions to the Board's governing regulations issued in the final rule published on May 23, 2008, Baylor had until October 20, 2008 to add any issues to its individual appeal.[71] A review of the transfer request forms shows the last date written thereon was for Friday, October 17, 2008 (several days later that the October 13, 2008 date listed on the SoP); however, the Group Representative failed to include proof of delivery or other documentation to establish that the Board actually received the add issue request and that the Board's receipt was on or before Monday, October 20, 2008, the filing deadline. Accordingly, the jurisdictional documentation submitted for Baylor fails to establish that the issues transferred to Case Nos. 15-2246GC and 15-2247GC were properly part of Case No. 08-1385 and, as such, the Board finds that it does not have jurisdiction over Baylor in either case for FY 2005.

#3 Provider 45-0137 – Baylor All Saints Medical Center (FYE 9/30/2005)

Baylor All Saints was issued a NPR on September 26, 2007. The Group Representative claims that the Provider submitted an appeal request on March 20, 2008 to establish the individual appeal under Case No. 08-1681. The Group Representative included as part of the SoPs an Acknowledgement from the Board that establishes that Case No. 08-1681 was filed with the Board on March 20, 2008, which would have been 176 days after the NPR was issued. However, the Group Representative failed to include a copy of the actual appeal request that was filed in order to document what issues are properly part of the appeal. As a result, the Group Representative has failed to establish that the Dual Eligible issues were timely appealed to be transferred from Case No. 08-1681 to these group appeals. Accordingly, the jurisdictional documentation submitted for Baylor fails to establish that the issues transferred to Case Nos. 15-2246GC and 15-2247GC were properly part of Case No. 08-1681 and, as such, the Board finds that it does not have jurisdiction over Baylor All Saints in either case for FY 2005.

#4 Provider 45-0280 – Baylor Medical Center at Garland (FYE 12/31/2005)

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[70] Provider included the 10/13/2018 date on the SOP, but the copy of the add issue was signed 10/15/08 and no proof of delivery was attached.

[71] *See* 73 Fed. Reg. 20190, 30240 (May 23, 2008) (stating "For appeals pending before . . . the Board prior to the effective date of this rule, a provider that wishes to add one or more issues to its appeal must do so by the expiration of . . . 60 days after the effective date of this rule [*i.e.*, 60 days after August 21, 2008]."). *See also* Board Alert 3.

Baylor Medical Center at Garland ("Garland") was issued an NPR on May 12, 2008 and filed and appeal request with the Board on November 10, 2008 to establish the individual appeal under Case No. 09-0237. The transfer request forms at issue transferred:

- Issue 6 entitled "Disproportionate Share Hospital Payment – Dual Eligible Days" from Case No. 09-0237 to Case No. 15-2246GC; and
- Issue 7 entitled "Disproportionate Share Hospital Payment – Exhausted Medicare Benefits Medicaid Dual Eligible Days" from Case No. 09-0237 to Case No. 15-2246GC.

Both Issue 6 and Issue 7 addressed "Whether the Intermediary properly excluded [certain days] from the DSH calculation" where Issue 6 concerned the exclusion of "Dual Eligible Days" and Issue 7 concerned "Exhausted Medicare Benefits Medicaid Dual Eligible Days." For Issue 6, Garland contended that "the Intermediary failed to include [the specified days] in the Medicare DSH calculation" and that such days "should have been included in the Medicaid percentage of the DSH calculation." Similarly, for Issue 7, Garland contended that "the Intermediary failed to include [the specified days] in the Medicaid percentage of the Medicare DSH calculation" and that such days "should have been included in the Medicaid percentage of the of the DSH calculation." These issue statements for Issue 6 and 7 in the individual appeal closely mirror the original group issue statements for Case Nos. 15-2246GC and 15-2247GC as quoted above in Section I.[72]

As discussed in Section II, the Secretary's policy for treatment of no-pay part A days involving dual eligible days and exhausted days involving dual eligible beneficiaries was to exclude them from ***both*** the SSI fraction (numerator and denominator) and the numerator of the Medicaid fraction.[73] However, as part of the FY 2005 IPPS Rule, the Secretary implement new policy requiring that no-pay Part A days and exhausted days be included in the SSI fraction. Given that Case Nos. 09-0540GC (QRS BHCS 97-05 DSH Dual Eligible Days CIRP) and 09-0541GC (QRS BHCS 97-05 Exhausted Part A Days CIRP) were established to encompass fiscal years both ***prior to*** and subsequent to the change of policy issued in the FY 2005 IPPS Final Rule, it must be presumed (without evidence to the contrary) that Case Nos. 09-0540GC and 09-0541GC did not challenge the SSI fraction. Indeed, the original issue statement for those cases does not mention the SSI fraction and only appealed or contested the exclusion of those classes of days from the Medicaid fraction. Further, for FYs 1997 up to October 1, 2004, the providers in those group would have been protesting the exclusion of such days from both the SSI fraction and the Medicaid fraction. As such, the Board must conclude that, for FYs 2005 (and 2007), participants in FYs 09-0540GC and 09-0541GC were appealing days excluded from both fractions (similar to

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[72] The Board recognizes that there were other DSH-related issues in Garland's individual appeal. However, there is ***no*** *evidence* that those issues were transferred to Case Nos. 09-0540GC and 09-0541GC from which Case Nos. 15-2246GC and 15-2247GC were bifurcated. Indeed, those other issues could have been transferred to other group appeals or, in the alternative, could have been dismissed when the Board dismissed Garland's individual appeal under Case No. 09-0237 for failure to file a final position paper. However, the Group Representative has not provided any information on the disposition of any of the other issues in Case No. 09-0237.

[73] Historically, the denominator of the Medicaid fraction has never been in dispute since it very clearly and simply includes total days (both Medicare and non-Medicare).

the providers that were part of the PRRB Dec. No. 2018-D43[74]). This means that when Case Nos. 14-2246GC and 15-2247GC were bifurcated from them they only concern dual eligible days and exhausted benefit dual eligible days that had been excluded from both the Medicare and Medicaid fractions. In this regard, the Board notes that, pursuant to 42 C.F.R. § 405.1837(f)(1), "After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, a provider may not add other questions of fact or law to the appeal, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart)." Accordingly, at the time of bifurcation, the Group Representative could not add issues to establish Case Nos. 15-2246GC and 15-2247GC that were not already present in groups from which they were being bifurcated.

In contrast, the EJR request encompasses different issues. The class of days involved in the EJR request is very different because it encompasses no-pay and exhausted days that were, in fact, counted or included in the SSI fraction per the FY 2005 IPPS Final Rule and, per that EJR request, the Providers are seeking to have that class of days excluded from the SSI fraction and included (to the extent they involve a dual eligible) included in the numerator of the Medicaid fraction. As such the class of days encompassed by the EJR request is much larger (*i.e.*, includes days outside of dual eligibles) and includes the SSI fraction which is not at issue in either Case Nos. 15-2246GC and 15-2247GC. This is borne out in the impact calculation (as well as associated narrative[75]) included behind Tab 4E which was prepared for the EJR request and only covers the class of days encompassed by the EJR request.[76]

The facts that a group appeal may contain only one issue and that the EJR request, along with estimated amounts in controversy, were submitted on an issue other than the one for which the group appeal was established, the Board must conclude that the Providers have abandoned the original group issue. Accordingly, the Board dismisses Garland, the sole remaining participant in these groups.[77] In dismissing Garland, the Board further notes that the Group Representative failed to include proper documentation in the SoP (or even the EJR request) of the original group issue statement that was used to establish Case Nos. 15-2248GC and 15-2247GC. This documentation is critical in order to determine jurisdiction and the Group Representative's failure to carry out its

[74] The Board's decision issued as PRRB Dec. No. 2018-D43 (July 5, 2018) concerned certain dual eligible days that were excluded from both the SSI fraction and the Medicaid fraction for FYs 2000 to FY 2009 (clearly after the FY 2005 IPPS Final Rule) because they were not billed to Medicare Part A.

[75] There is no evidence that this narrative behind Tab 4E was included in the original appeal rquest.

[76] While the Group Representative failed to include the impact analysis that was filed with Garlands individual appeal request that was used to establish Case No. 09-0237, that appeal request does document that the impact for Issue 6 was $15,000 and for Issue 7 was $21,000. This is different to the impact behind Tab 4E of $23,338 and $60,466 for the two CIRPs.

[77] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

> The Board may dismiss a case or an issue on its own motion:
> • If it has a reasonable basis to believe that the issues have been fully settled or abandoned:
> • Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

responsibilities to provide this documentation pursuant to Board Rules 20 and 21 is an independent basis for dismissal, as a remedial measure.

The Board finds for Provider's #1, #3 and #4 that they have not submitted the required jurisdictional documentation to support the timely appeal, and transfer of the Dual Eligible Days issues to 15-2246GC and 15-2247GC. It is the Providers responsibility to include the required jurisdictional documentation in the schedule of providers, and they have failed to do so. The Board is unable to establish for each of the Providers, that they have valid appeals of the Dual Eligible days (as represented in the EJR request) in either case, therefore they are hereby dismissed.

C. Board's Decision Regarding the EJR Request

The Board finds that, for both CIRP groups,:

1) Participant #2 (Prov. No. 45-0021 – Baylor University Medical System (FYE 6/30/2007)) was also a participant of Case Nos. 13-3896GC and 13-3938GC for the same issue and for the same fiscal year, in violation of 405.1837(b)(1) and (e) and Board Rule 4.6, and, accordingly, is dismissed from the appeals;

2) Participant #1 (Prov. No. 45-0021 – Baylor University Medical System (FYE 6/30/2005)) failed to establish that the issues transferred to these 2 CIRP groups was properly added to the individual appeal prior to those transfers and, accordingly, is dismissed from the appeals;

3) Participant #3 (Prov. No. 45-0137 – Baylor All Saints Medical Center (FYE 9/30/2005)) is unable to document that the group issues were timely appealed because it failed to include a copy of the appeal request used to establish the individual appeal from which it purportedly transferred into the 2 CIRP groups and, accordingly, is dismissed from the appeals; and

4) Participant #4 (Prov. No. 45-0280 – Baylor Medical Center at Garland (FYE 12/31/2005)) did not transfer into Case Nos. 15-2246GC and 15-2247GC the issues that are the subject of the EJR request and is dismissed due to abandonment of the original issues in those cases and the Group Representatives failure to meet its responsibility under Board Rules 20 and 21.

Accordingly, there are no providers remaining in these appeals due to the above dismissals. Accordingly, the Board denies the EJR request for both appeals, as jurisdiction is a prerequisite to EJR. 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. As no providers remain, the appeals are now closed.

<u>Board Members Participating:</u>

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

FOR THE BOARD:

6/13/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Ave., Ste. 570A
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RE: ***EJR Determination***
17-1080GC QRS Houston Methodist 2005 DSH SSI Fraction Dual Eligible Days CIRP
17-1081GC QRS Houston Methodist 2005 DSH Medicaid Fraction Dual Eligible Days CIRP
17-1182GC QRS BSWH 2006 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1183GC QRS BSWH 2006 DSH Medicaid Fraction Dual Eligible Days CIRP
18-0110GC QRS CHS 2014 DSH SSI/Medicaid Dual Eligible Days CIRP Group

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") has reviewed the May 13, 2022 consolidated request for expedited judicial review ("EJR")[1] in the above-referenced five (5) common issue related party ("CIRP") group appeals involving several CIRP organizations that the Group Representative, Quality Reimbursement Services, Inc. ("QRS"), filed on behalf of the Providers. The decision of the Board is set forth below. As explained by letter dated June, 3, 2022, the 30 day period for responding to the EJR request had not yet begun because the Board had not yet completed its jurisdictional review and that the 30-day clock would not begin until the completion of that process because 42 C.F.R. § 405.1837(b)(2) specifies that "the 30-day period for the Board to make a determination [on an EJR request] 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." The Board has completed its jurisdictional review and, set forth below, is the Board's jurisdictional determination. The Board is also simultaneously issuing its EJR determination as the Board is well versed in the issues covered by the EJR request.

[1] QRS also requested EJR over an additional eight appeals on May 13, 2022. Four of those appeals, 21-0971GC DCH Health CYs 2011 & 2014 -2015 DSH SSI Fraction Dual Eligible Days, 21-0974GC DCH CYs 2011 & 2014 - 2015 DSH Medicaid Fraction Dual Eligible Days CIRP, 21-0979GC DCH Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group and 21-0982GC DCH Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP, FSS requested, and the Board approved an extension for FSS and the MAC to review the jurisdictional documents and provide comments on jurisdiction. *See* the Board's Status of EJR Request & Notice of when the 30-Day Period Commences, which includes the extension for FSS/MAC to reply, dated June 3, 2022. As the Board previously granted an extension, the Board will not address those four appeals in this EJR determination. In addition, there are 4 other group appeals, for which the Board will issue correspondence under separate cover. QRS did ***not*** object to either the Board's grant of the extension or the Board's notice of when the 30-day period commences.

I. Issue in Dispute

Pursuant to 42 C.F.R. § 405.1837(a), "a provider . . . has a right to a Board hearing, as part of a group appeal with other providers, . . . ***only if*** . . . [t]he mater 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 . . . ."[2] To this end, § 405.1837(f) addresses the following "Limitations on group appeals":

> (1) After the date of receipt by the Board of a group appeal hearing request under paragraph (c) of this section, *a provider may* ***not*** *add other questions of fact or law to the appeal*, regardless of whether the question is common to other members of the appeal (as described in § 405.1837(a)(2) and (g) of this subpart).
>
> (2) The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart -
>
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question ***common*** *to each provider*; and
>
> (ii) When the appeal is found to involve more than one factual or legal question ***common to each provider***, the Board must assign a separate case number to the appeal of each ***common*** factual or legal question and conduct further proceedings in the various appeals separately for each case.[3]

For each year at issue, two CIRP groups were established, with one CIRP group addressing the "SSI Fraction/Dual Eligible Days" issue and the other addressing the "Medicaid Fraction/Dual Eligible Days" issue. In their group issue statement for the "SSI Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead MAC should have included in the Medicaid fraction of the DSH calculation patient

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

> days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> **Statement of Legal Basis**
>
> The Provider(s) contend(s) that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider(s) contend(s) that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Providers' contention that these days must be excluded from both the numerator and the denominator of the SSI percentage factor in the Medicare DSH formula.[4]

Similarly, in their group issue statement for the "Medicaid Fraction/Dual Eligible Days" issue, the Providers frame the issue as follows:

> **Statement of Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid

[4] *E.g.*, Group Issue Statement for Case 17-1080GC.

> percentage of the Medicare Disproportionate Share Hospital ("DSH") calculation. Further, whether the Lead MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.
>
> **Statement of Legal Basis**
>
> The Provider contends that the Lead MAC did not allow patient days associated with certain Medicare Part A and Title XIX dual eligible patients to be included in the numerator of either the SSI percentage or the Medicaid Percentage of the Medicare DSH calculation. These patients were eligible for Medicare Part A benefits, however, no payments were made by Medicare Part A for these patients. The Lead MAC did not allow the days to be included in the Medicaid Proxy and CMS did not include the days in the calculation of the SSI percentage. In some instances, such days were included in the denominator of the SSI percentage.
>
> CMS has represented to several Federal courts that the Medicare/SSI fraction only counts Medicare paid days. See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala, 97 F.3d 1261, 1265 (9th Cir. 1996).
>
> While CMS has stated that the SSI fraction would only include patient days paid by Medicare Part A, intermediaries have refused to recognize these dual eligible patient days, which lack Medicare Part A payments, in the Medicaid percentage of the Medicare DSH payment calculation. Since CMS has stated that only "paid" days will be used in the SSI percentage, the Provider(s) contend(s) that the terms **paid** and **entitled** must be consistent with one another due to the usage of the two terms in 42 C.F.R. § 412.106(b) and CMS testimony. The numerator of the SSI percentage requires SSI payments to have been made, thus the denominator should also require Part A payment.
>
> It is the Provider's contention that these days must be included in the Medicaid percentage.[5]

While the two issue statements are essentially the same, the Board required the formation of two separate groups for each year as there are two separate legal issues involved in the issue statement where, as denoted by the title of each group, one applies to the DSH SSI fraction and the other to the DSH Medicaid fraction. Specifically, the CIRP group for the "SSI Fraction/Dual Eligible Days" issue challenges the inclusion of noncovered Medicare days in the SSI fraction

[5] *E.g.*, Group Issue Statement for Case 17-1081GC.

(as mandated by the regulatory revisions made by the FY 2005 IPPS Final Rule); and the CIRP group for the "Medicaid Fraction/Dual Eligible Days" issue alleges that, if the days at issue are excluded from the SSI fraction (*i.e.*, following a successful reversal of the regulatory revisions made by the FY 2005 IPPS Final Rule), then the subset of days that are associated with Medicaid eligible patients should be included in the numerator of the Medicaid fraction (as opposed to simply being excluded from the SSI fraction and the numerator of the Medicaid fraction as was done prior to the FY 2005 IPPS Final Rule). In this regard, the Board notes that, consistent with 42 C.F.R. § 405.1837(a), it has historically required the formation of two separate groups for the Exhausted Part A Days issue as it relates to the SSI and Medicaid Fractions when the issue statement for the group request exclusion of no-pay Part A days from the SSI fraction and inclusion of the subset of those days involving dual eligible in the numerator of the Medicaid fraction. The Board more fully explains in Section IV, below, why there are two separate issues, one involving the Medicare fraction and the other involving the Medicaid fraction.

Although CHS 2014 initially filed two separate appeals with the distinct issue statement, on August 12, 2021, the Board consolidated, in error, both fractions in Case Nos. 18-0110GC and 18-0111GC, into a single issue group for both fractions, renaming 18-0110GC QRS CHS 2014 DSH SSI/Medicaid Dual Eligible Days CIRP Group. The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where, such as here, the Board may have previously consolidated these two issues in error. Since the Board has determined jurisdiction is proper for all participants in Case No. 18-0220GC for both issues (as discussed in Section IV.A below), and for the sake of judicial economy, the Board is hereby bifurcating the CIRP Group into the following cases, as reflected in the attached Schedules of Providers:

- 18-0110GC (A) – QRS CHS 2014 DSH SSI Fraction Dual Eligible Days CIRP Group
- 18-0110GC (B) – QRS CHS 2014 DSH Medicaid Fraction Dual Eligible Days CIRP Group

Accordingly, the Board views the EJR request as a consolidated EJR request encompassing both CIRP groups for each of the years at issue.

II. <u>Statutory and Regulatory Background:</u>

A. Adjustment for Medicare DSH

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").[6] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[7]

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[6] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[7] *Id.*

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[8] 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.[9]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[10] 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.[11] The DPP is defined as the sum of two fractions expressed as percentages.[12] 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, 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 . . . .[13]

The Medicare/SSI fraction is computed annually by the Centers for Medicare & Medicaid Services ("CMS"), and the Medicare contractors use CMS' calculation to compute an eligible hospital's DSH payment adjustment.[14]

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.[15]

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[8] *See* 42 U.S.C. § 1395ww(d)(5).
[9] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[10] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[11] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[12] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).
[13] (Emphasis added.)
[14] 42 C.F.R. § 412.106(b)(2)-(3).
[15] (Emphasis added.)

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.[16]

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the preamble to FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[17] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[18]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under this policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[19] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[20] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[21]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C § 1395ww(d)(5)(F)(vi)(II).[22] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[23] to differentiate the days for dual eligible patients whose Part A coverage had been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identification. Underlying the Secretary's concern was the fact that there were

[16] 42 C.F.R. § 412.106(b)(4).
[17] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.* at 27207-27208.
[22] *Id.* at 27207-08.
[23] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

hospitals located in States where no Part A bill may be submitted for the beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[24]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[25] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[26] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[27]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[28] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[29]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[30] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addressed the previously proposed policy changes and recognized that it had "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003 . . . . In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient days are counted in the Medicare fraction. This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are

[24] 68 Fed. Reg. at 27208.
[25] *Id.*
[26] *Id.*
[27] *Id.*
[28] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[29] *Id.*
[30] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (http://www.cms.hhs.gov/providers/hipps/dual.asp) on July 9, 2004.[31]
>
> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation.*[32]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[33] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[34] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *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 and SSI, excluding those patients who received only State supplementation . . .[35]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

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[31] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004) (emphasis added).
[32] *Id.* at 49099 (emphasis added).
[33] *Id.*
[34] *See id.* at 49099, 49246.
[35] (Emphasis added.)

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation. . . .[36]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[37]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[38] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 IPPS final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction. . . . *Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[39]

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[36] (Emphasis added.)
[37] *Id.*
[38] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in questions (*i.e.*, was a dual eligible).
[39] (Citations omitted and emphasis added.)

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[40] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[41] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[42] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[43] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[44] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[45] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp. v. Sebelius*,[46] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[47]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[48] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[49] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R. § 412.106(b)(2) was substantively and procedurally invalid.[50] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently,

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[40] 317 F. Supp. 3d 168 (D.D.C. 2018).
[41] *Id.* at 172.
[42] *Id.* at 190.
[43] *Id.* at 194.
[44] *See* 2019 WL 668282.
[45] 718 F.3d 914 (2013).
[46] 657 F.3d 1 (D.C. Cir. 2011).
[47] 718 F.3d at 920.
[48] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[49] *Id.* at 1141.
[50] *Id.*

the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[51] and that the regulation is procedurally invalid.[52]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[53] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[54] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[55] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[56] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[57] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[58] Accordingly, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[59] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

2. It "reinstat[ed] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[60] Thus, as of the date of this decision, the Secretary's position with respect

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[51] *Id.* at 1162.
[52] *Id.* at 1163
[53] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[54] *Id.* at 884.
[55] *Id.* at 884.
[56] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[57] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[58] *Id.* at 886.
[59] *Id.*
[60] *Becerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

to the validity of 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position

The Providers are challenging the inclusion of certain non-covered (Part A exhausted) patient days in the Medicare fraction. They argue that these no-pay Part A days should either be in the numerator *and* denominator of the Medicare fraction, or excluded from both and instead recognized in the numerator of the Medicaid fraction. They argue that the amendments effective October 1, 2004 to 42 C.F.R. § 412.106(b)(2)(i), which mandate inclusion of the Part A exhausted benefit days be included in the Medicare fraction, are invalid. They claim that the 2004 rulemaking violates the Administrative Procedure Act ("APA") due to inadequate notice and because the final rule was not the product of reasoned decision-making. The Provider's further contend that the unambiguous language of the Medicare Act mandates exclusion of no-pay Part A days from the Medicare fraction. The Providers maintain that their position is consistent with the decision in *Empire Health Foundation v. Azar* (as referenced above). Finally, the Providers contend that the unambiguous language of the Medicare Act mandates inclusion of no-pay Part A days in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible.

The Providers note that there are no factual issues to be resolved and that the issue involves whether as a matter of law the regulations mandating inclusion of no-pay Part A days in the Medicare fraction are illegal and that such days must be included in the Medicaid fraction to the extent the relevant underlying patient was also Medicaid eligible. Since the Board has jurisdiction and the issue involves a challenge to the validity of one of the Secretary's regulations, the Providers request the Board grant EJR.

IV. Decision of the Board

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

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

1. Statutory and Regulatory Background

All of the participants in the 5 CIRP groups appealed cost reporting periods beginning prior to January 1, 2016. For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming it as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital*

Association v. Bowen ("*Bethesda*").[61] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[62]

On August 21, 2008, new regulations governing the Board were effective.[63] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[64] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[65]

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

For any participant that files an appeal from a revised NPR issued after August 21, 2008, the Board only has jurisdiction to hear that participant's appeal of matters that the Medicare contractor specifically revised within the revised NPR. The Board notes that all of the remaining participant revised NPR appeals included within this EJR request were issued after August 21, 2008.

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[61] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self-disallowed the item.).
[62] *Bethesda*, 108 S. Ct. at 1258-59.
[63] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[64] 201 F. Supp. 3d 131 (D.D.C. 2016).
[65] *Id.* at 142.

B. Appeals of Revised NPR's

There are four group appeals, where each of the Providers in those appeals, appealed from Revised NPR's.

17-1080GC QRS Houston Methodist 2005 DSH SSI Fraction Dual Eligible Days CIRP
17-1081GC QRS Houston Methodist 2005 DSH Medicaid Fraction Dual Eligible Days CIRP

Provider 1. The Methodist Hospital (Prov. No. 45-0358, FYE 12/31/2005)

This Provider appealed a revised NPR issued January 21, 2016. The Audit adjustment indicated that the MAC reopened the cost report to adjust the SSI% based on the CMS Ruling 1498-R SSI remand in the prior PRRB Case No. 00-1229GC. Pursuant to that 1498-R remand, CMS re-ran the data matching process and generated a new SSI fraction.[66] The audit adjustments reflect an adjustment to the SSI % but do not reflect a revision to Medicaid days in the Medicaid fraction. Rather, only the SSI fraction was adjusted.

Provider 2. San Jacinto Methodist Hospital (Prov. No. 45-0424, FYE 12/31/2005)

The Provider appealed a revised NPR issued January 12, 2016. The Audit adjustment indicated that the MAC reopened the cost report to adjust the SSI% accordingly. The record before the Board shows that this provider was part of the same 1498-R SSI remand and that, pursuant to that 1498-R remand, CMS re-ran the data matching process and generated a new SSI fraction. The audit adjustments reflect an adjustment to the SSI % but do not reflect a revision to Medicaid days as used in the Medicaid fraction. Rather, only the SSI fraction was adjusted.

17-1182GC QRS BSWH 2006 DSH SSI Fraction Dual Eligible Days CIRP Group
17-1183GC QRS BSWH 2006 DSH Medicaid Fraction Dual Eligible Days CIRP

Provider 1. Baylor Medical Center at Irving (Prov. No. 45-0079, FYE 6/30/2006)

This Provider appealed a revised NPR issued January 28, 2016. The Audit adjustment indicated that the MAC reopened the cost report to adjust the SSI% based on the 1498-R SSI

[66] This situation does ***not*** encompass a realignment of the SSI percentage because CMS does ***not*** rerun the data match process in order to effectuate a realignment but rather uses pre-existing data previously gathered on a month-by-month basis to effectuate the realignment. *See* 42 C.F.R. § 412.106(b)(2) (noting that CMS gathers data on a month-by-month basis); 75 Fed. Reg. 50042, 50279 (Aug. 16, 2010) (stating: "The SSI fractions are generally based on the Federal fiscal year; however, 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 from the data match process for the two Federal fiscal years that spanned the hospital's cost reporting period.); 70 Fed. Reg. 47278, 47439 (Aug. 12, 2005) (stating: "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 or not it is a more favorable number than the DSH percentage based on the Federal fiscal year*." (emphasis added)).

remand in the prior PRRB Case No. 08-2975GC and that the data matching process was re-run to generate a new SSI fraction. The audit adjustments reflect an adjustment to the SSI % but do not reflect a revision to Medicaid days as use in the Medicaid fraction. Rather, only the SSI fraction was adjusted.

Provider 2. Baylor All Saints (Prov. No. 45-0137, FYE 9/30/2006)

The Provider appealed a revised NPR issued December 30, 2015. The Audit adjustment indicated that the MAC reopened the cost report to adjust the SSI% to the latest amount released by CMS based on a re-running of the data match process. The audit adjustments reflect an adjustment to the SSI % but do not reflect a revision to Medicaid days as used in the Medicaid fraction. Rather, it only adjusted the SSI fraction.

Provider 3. Baylor Medical Center at Garland (Prov. No. 45-0280, FYE 12/31/2006)

This Provider appealed a revised NPR issued January 26, 2016. The Audit adjustment indicated that the MAC reopened the cost report t to adjust the SSI% to the latest amount released by CMS based on a re-running of the data match process. The audit adjustments reflect an adjustment to the SSI % but do not reflect a revision to Medicaid days as used in the Medicaid fraction. Rather, it only adjusted the SSI fraction.

Provider 4. Baylor Scott and White (Prov. No. 45-0742, FYE 5/3012006)

The Provider appealed a revised NPR issued March 15, 201**9** which is 3 years roughly after the other participants received their revised NPR suggesting that it was ***not*** issued as a result of a 1498-R remand. To this end, the reopening notice dated June 27, 2017 makes it clear that the reopening was for realignment, namely "[t]o update the SSI percentage and DSH payment percentage per Provider's request to recalculate the SSI percentage using their cost report Fiscal Year." The audit adjustment report simply incorporated the new SSI% updated based on the provider's fiscal year as released by CMS.

The regulation, 42 C.F.R. § 405.1889, limits the appeal of revised NPRs to issues which were adjusted as part of the cost report reopening. The regulation states that:

> 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 . . . § 405.1835 . . .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.

Since, pursuant to 42 C.F.R. § 405.1842(a) jurisdiction over an appeal is a prerequisite to granting a request for EJR, the Board denies jurisdiction over each of the providers in both Medicaid fraction appeals, 17-1081GC QRS Houston Methodist 2005 DSH Medicaid Fraction Dual Eligible Days CIRP and 17-1183GC QRS BSWH 2006 DSH Medicaid Fraction Dual Eligible Days CIRP, as each provider in those appeals appealed from RNPRs that did not adjust the Medicaid fraction.

In addition, the Board denies jurisdiction over Baylor Scott and White Lake Pointe (Prov. No. 45-0742, FYE 5/3012006) in Case No. 17-1182GC concerning the SSI fraction because the revised NPR was only issued to effectuate a realignment of the Provider's SSI fraction from the federal fiscal year to the Provider's fiscal year.[67] The Board finds that it does not have jurisdiction over either the SSI fraction or the Medicaid fraction issues covered by the EJR request because the Provider appealed from the revised NPR was issued as a result of the Provider's SSI Realignment request, and did not adjust either of these two issues. 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).

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

[67] *See supra* note 66.

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[68]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[69] 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 *from the data match process **for the two Federal fiscal years that spanned the hospital's cost reporting period***."[70]

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 or not it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   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."[71]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g.*, no pay Part A days) 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

[68] (Emphasis Added.)
[69] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[70] (Emphasis Added.)
[71] (Emphasis Added.)

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 provider "must accept" the realigned SSI percentage.

Since the only matter specifically revised in the revised NPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, Baylor Scott & White Lake Pointe does not have a right, under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1), to appeal the issues covered by the EJR request.

Finally, the Board also denies the request for EJR for Case Nos. 17-1181GC and 17-1183GC as jurisdiction is a prerequisite to EJR. Further, for the remaining participants in Case Nos. 17-1180GC and 17-1182GC, the Board only grants EJR as it relates to the first issue as explained below. In making the above rulings, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[72]

C. Jurisdictional Determination over the remaining providers from original NPR's

The Board has determined that providers in 18-0110GC (A) and (B) for which EJR was submitted, appealed the Exhausted Part A/Dual Eligible Days issues for CY 2014 and are governed by CMS Ruling CMS-1727-R since they are challenging the FY 2005 IPPS Final Rule and that Board review of the issues is not otherwise precluded by statute or regulation. In addition, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[73] The appeals were timely filed and no jurisdictional impediments have been identified for those participants. Based on the above, the Board finds that it has jurisdiction for the providers in 18-0110GC (A) and (B).

D. Board's Analysis of the Appealed Issue

The remaining CIRP group appeals in these EJR requests involve the 2005 to 2014 cost reporting periods and each FY includes 2 CIRP groups and involve the ***same*** participants. 42 C.F.R. § 405.1867 specifies that "[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* . . . ."[74] Consequently the Board finds that it is bound by the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) and the Board does not have the authority to grant the relief sought by the Providers, namely: (1) invalidating the amendments FY 2005 IPPS Final Rule, as amended, so as to exclude no-pay Part A days from the SSI fraction; and (2) including the subset of such days for which the underlying patients were

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[72] *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).
[73] *See* 42 C.F.R. § 405.1837.
[74] (Emphasis added.)

Medicaid eligible in the numerator of the Medicaid fraction. As a result, the Board finds that EJR is appropriate for the issue and calendar year under appeal in each of these cases.

In making this finding, the Board notes that, as described above, the Providers maintained in their EJR Request that the FY 2005 IPPS Final Rule mandating that no-pay Part A days be counted in the SSI fraction should be invalidated, and such days should instead be counted in the patient days ratio of the Medicaid fraction (to the extent the days involve a dual eligible), and that this is consistent with the *Empire* ruling. However, as evidenced by the Ninth Circuit's decision in *Empire,* the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the Ninth Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Services v. Sebelius* ("*Allina*").[75] In *Allina*, the Ninth Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in *Allina* stated: "the statute unambiguously requires that Part C days be counted in one fraction or the other (a Part C-enrolled individual is either eligible for Medicare Part A, or not)."[76]

In contrast, this case involves no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[77] To this end, the Providers are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute, any days associated with no-Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

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[75] 746 F.3d 1102, 1108 (D.D. Cir. 2014).
[76] *Id.* (emphasis added).
[77] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

Accordingly, the Board disagrees with the Providers' position that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[78] and (2) CMS Ruling 1498-R, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI Fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 C.F.R. 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changed to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[79]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Medical Center v. Blue Cross Blue Shield Association* ("*Edgewater*").[80] Thus, in the event the Supreme Court upholds the Ninth Circuit's decision in *Empire,* the Providers would be arguing that CMS' prior policy of excluding from the numerator of the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.

Accordingly, the Board continues to maintain that the Provider's legal argument for the "SSI Fraction/Dual Eligible Days" issue advocating for exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the Provider's legal argument for the "Medicaid Fraction/Dual Eligible Days" issue advocating inclusion of the subset of no-pay part A days that

[78] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.
[79] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[80] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").

involve patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction. As a consequence, the Board is treating the Providers' EJR Request as a consolidated request involving two separate issues – Dual Eligible, Non-Covered or Exhausted Part A Days in both the SSI and Medicaid fractions.

E. Board's Decision Regarding the EJR Request

The Board finds that:

1) It lacks jurisdiction over the following participants:

    a. The two participants in Case No. 17-1081GC QRS Houston Methodist 2005 DSH Medicaid Fraction Dual Eligible Days CIRP and the 4 participants in Case No. 17-1183GC QRS BSWH 2006 DSH Medicaid Fraction Dual Eligible Days CIRP because the providers each appealed from RNPRs that did not adjust the Medicaid fraction (note that these appeals are dismissed in total as ***no*** providers remain); and

    b. Baylor Scott and White Lake Pointe (Prov. No. 45-0742, FYE 5/3012006) in Case No. 17-1182GC concerning the SSI fraction because the revised NPR was only issued to effectuate a realignment of the Provider's SSI fraction from the federal fiscal year to the Provider's fiscal year and did not adjust the SSI fraction for no-pay part A days.

2) It has jurisdiction over the matter for the subject years and the remaining providers in Case No. 17-1182GC as well as the Providers in Case Nos. 17-1180GC, 18-0110GC(A), and 18-0110GC(B) and that they are entitled to a hearing before the Board as part of these group appeals;

3) Based upon the Providers' assertions regarding 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule), there are no findings of fact for resolution by the Board;

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

5) It is without the authority to decide:

    a. The legal question in Case Nos. 17-1080GC, 17-1082GC, and 18-0110GC(A) of whether 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) is valid; and

    b. If it is not valid, the legal question in Case Nos. 17-1081GC, 17-1083GC, and 18-0110GC(B) 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[81]) also excluded those days from the numerator of the Medicaid fraction in situations involving a dual eligible.[82]

Accordingly, the Board finds that the questions in Finding 5 above properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years in the remaining group appeals as modified and set forth in Finding 5 The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The cases are now closed.[83]

Board Members Participating:

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

FOR THE BOARD:

6/13/2022

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

Enclosure: Schedules of Providers

cc: Bill Tisdale, Novitas Solutions (J-H)
Wilson Leong, FSS

[81] The Providers would go beyond *Empire* and contend 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.

[82] The Board has not identified any other issues outside of these questions for which EJR is requested, particularly since as discussed in *infra* note 72, there may be only one issue per group.

[83] In closing these cases, the Board notes that, per 42. C.F.R. § 405.1837(a), there may only be one issue per group. As explained in Section IV, the Board found that the consolidated EJR request only pertained to two legal issues one pertaining to the SSI fraction (as embodied in Case Nos. 17-1080GC, 17-1182GC, 18-0110GC(A)) and one pertaining to the Medicaid fraction (as embodied in 17-1081GC, 17-1183GC, 18-0110GC(B)). Further, the Board finding of jurisdiction over the group is a prerequisite to granting EJR and, thus, dependent upon the Board finding that there is only one issue in each group.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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RE: ***EJR Determination***
19-1840GC Houston Methodist CY 2014 DGME Fellow Penalty Present Year CIRP Group
19-1839GC Houston Methodist CY 2014 DGME Fellow Penalty Prior and Penultimate Years CIRP
20-2068G King & Spalding CY 2015 DGME Fellow Penalty Prior & Penultimate Years III Grp.

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 23, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Providers describe the DGME Penalty issue as follows:

> The solitary issue presented in this request for EJR is whether the formula for calculating the number of full-time equivalent ("FTE") residents a hospital may count in a year for the purposes of direct graduate medical education reimbursement, as contained in 42 C.F.R. 413.79(c)(2)(iii), is unlawful because it penalizes hospitals that train "fellows" (*i.e.*, residents who are not in their initial residency period) while operating in excess of their FTE caps (the "Fellow Penalty" issue). Following a grant of EJR by this Board, the District Court for the District of Columbia answered this question in the affirmative. *See Milton S. Hershey Med. Ctr. V. Becerra,* 19-CV-3411, 2021 WL 1966572, (D.D.C. May 17, 2021), *appeal dismissed, 21-5169, 2021 WL 4057675 (D.C. Cir. Aug. 23, 2021*) (Secretary's formula for counting DGME FTEs, as applied to plaintiff hospitals, violates plain language of the Medicare statute). The Providers also challenge the Secretary's regulation and seek relief in the form of an adjustment to their FTE counts for their present, prior and penultimate years for the cost reporting periods under appeal. The Providers have filed separate group appeals for the present year issue and the prior and penultimate year issues. For the purposes of this EJR request, the Providers will refer to both issues collectively as a single issue.[1]

[1] Providers' Consolidated EJR Request at 1-2 (May 23, 2022).

Background

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

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

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

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

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

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

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

[2] of the Department of Health and Human Services.
[3] 42 U.S.C. § 1395ww(h).
[4] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[5] 42 U.S.C. § 1395(h).
[6] "Initial residency period" is defined in the statute as the minimum number of years required for Board eligibility. 42 U.S.C. § 1395ww(h)(5)(F).

assignment, a hospital that trained 10 IRPs and 10 fellows in a given year would have a weighted FTE count of 15.

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

> [F]or purposes of a cost reporting period beginning on or after October 1, 1997 . . . the total number of full-time equivalent residents before the application of the weighting factors (as determined under this paragraph) with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine *may not exceed* the number (or 130 percent of such number in the case of a hospital located in a rural area) of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

> *To address situations in which a hospital increases the number of FTE residents **over** the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of

[7] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[8] 42 U.S.C. § 1395ww(h)(4)(F)(i) (emphasis added). Further, 42 U.S.C. § 1395ww(h)(4)(H) directs the Secretary to establish rules for determining the caps of hospitals that establish new programs after December 31, 1996.
[9] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

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

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

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively,

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

> will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[12]

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

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

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

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[12] *Id.* at 39894 (emphasis added).
[13] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that was in the prior version of the regulation and replacing it them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.

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

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

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

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

The Providers' Position

The Providers assert that the MAC's calculations of the current, prior-year and penultimate-year DGME FTES and the FTE caps are contrary to the statutory provisions at 42 U.S.C. § 1395ww(h), and, as a result, the Providers' DGME payments are understated. The Providers contend that the regulation implementing the cap and the weighting factors is contrary to the statute because it determines the cap after the application of the weighting factors.[17] The effect of this regulation is to impose on the Providers weighting factors that result in reductions greater than 0.5 for many residents who are beyond the IRP, and the regulation prevents the Providers from claiming and receiving reimbursement for their full unweighted FTE caps.[18]

The Providers explain that the Medicare statute caps the number of residents that a hospital can claim at the number it trained in cost years ending in 1996.[19] The statute states that, for residents beyond the IRP, "the weighting factor is .50."[20] The statute also states that the current year FTEs are capped before application of the weighting factors: "the total number of full-time equivalent residents before application of the weighting factors . . . may not exceed the number . . . of such full-time equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996."[21] The Providers conclude that this statutory scheme sets an absolute weighting factor on fellows of 0.5 and requires that the weighting factors are not applied when capping the current year FTEs.

---

[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")
[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[17] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[18] 42 C.F.R. § 413.79(c)(2).
[19] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[20] *Id.* at § 1395ww(h)(4)(C)(iv).
[21] *Id.* at 1395ww(h)(4)(F)(i).

The Provider alleges that the regulation is "arbitrary and capricious and contrary to the Medicare statue because it distorts the weighting factors use to calculate the resident FTE count such that hospitals that train more fellows are unfairly financially penalized in certain circumstances." [22] Finally, the Provider states that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[23]

The Providers claim that it meets the jurisdictional dissatisfaction requirement for this issue pursuant to CMS Ruling 1727-R and because it self-disallowed the amount sought based on the Medicare Contractor being bound by regulation.[24] It argues that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant its request for EJR.[25]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (2013), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

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

For purposes of Board jurisdiction over a participant's appeals for cost report periods ending on or after December 31, 2008, the participant may demonstrate dissatisfaction with the amount of Medicare reimbursement for the appealed issue by claiming the SSI/Part C issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[26] In that case, the Supreme Court concluded that a cost report submitted in full compliance with the Secretary's rules and regulations, does not bar a provider from claiming dissatisfaction with the amount of reimbursement allowed by the regulations. Further, no statute or regulation expressly mandated that a challenge to the validity of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[27]

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[22] Providers' Consolidated Request for Expedited Judicial Review at 3 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, No. 19-2628 (May 17, 2021)).
[23] *Id.* at 10
[24] *Id.* at 13.
[25] *Id.* at 15
[26] 108 S. Ct. 1255 (1988). *See also* CMS Ruling CMS-1727-R (in self-disallowing an item, the provider submits a cost report that complies with the Medicare payment policy for the item and then appeals the item to the Board. The Medicare Contractor's NPR would not include any disallowance for the item. The provider effectively self- disallowed the item.).
[27] *Bethesda*, 108 S. Ct. at 1258-59.

On August 21, 2008, new regulations governing the Board were effective.[28] Among the new regulations implemented in Federal Register notice was 42 C.F.R. § 405.1835(a)(1)(ii) which required for cost report periods ending on or after December 31, 2008, providers who were self-disallowing specific items had to do so by following the procedures for filing a cost report under protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*").[29] In *Banner*, the provider filed its cost report in accordance with the applicable outlier regulations and did not protest the additional outlier payment it was seeking. The provider's request for EJR was denied because the Board found that it lacked jurisdiction over the issue. The District Court concluded that, under *Bethesda,* the 2008 self-disallowance regulation could not be applied to appeals raising a legal challenge to a regulation or other policy that the Medicare Contractor could not address.[30]

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

The Board has determined that the Providers involved with the instant EJR request involve a cost report periods which began prior to January 1, 2016 and are governed by CMS Ruling CMS-1727-R as they are challenging the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii). In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[31] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying providers. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

B. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals that exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows. Specifically, the Providers present the following equation in its request for EJR used to calculate the allowable count for primary residents and separately for nonprimary care residents: [32]

[28] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[29] 201 F. Supp. 3d 131 (D.D.C. 2016).
[30] *Id.* at 142.
[31] *See* 42 C.F.R. § 405.1839.
[32] EJR Request at 9.

$$\text{Allowable FTE count} = \text{Weighted FTE Count x}\left(\frac{\text{Unweighted FTE Cap}}{\text{Unweighted FTE Count}}\right)$$

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[33] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[34] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit], the hospital's weighted FTE count (before application of the limit) for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, *will be reduced* ***in the same proportion*** that the number of FTE residents for that cost reporting period exceeds the number of FTE residents for the most recent cost reporting period ending on or before December 31, 1996 [*i.e.*, the FTE cap or limit].[35]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap

[33] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[34] 66 Fed. Reg. at 39894 (emphasis added).
[35] (Emphasis added.)

applicable for the fiscal year.[36] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[37] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[38] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[39]

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

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

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

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

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

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

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

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

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

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:

6/14/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Denial of EJR & Dismissal of Cases***

13-3517GC Patton Boggs ("PB") 2009 DSH Dual Eligible-Lee Memorial Group
13-3858GC PB 2011 DSH Dual Eligible-Lee Memorial NPR Group
14-0912GC PB 2008 DSH Dual Eligible-Lee Memorial Group
14-4025GC PB 2012 DSH Dual Eligible Medicaid & Medicare Part A Days – Lee Mem'l Grp.
14-4283GC Squire Patton Boggs ("SPB") 2010 DSH Dual Elig. Medicaid & Medicare Part A Days – Lee Mem'l NPR Group
15-3370GC SPB 2013 DHS Dual Eligible Medicaid & Medicare Part A Days – Lee Mem'l Grp
16-2436GC SPB 2014 DSH Dual Eligible Medicaid & Medicare Part A Days – Lee Mem'l Grp
17-2090GC SPB 2015 DSH Dual Eligible Medicaid & Medicare Part A Days – Lee Mem'l Grp
18-1814GC Lee Mem'l CY 2016 DSH Dual Eligible Medicaid & Medicare Part A Days

Dear Mr. Collins:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' March 14 and 30, 2022[1] requests for expedited judicial review ("EJR") that were filed in the above-referenced nine (9) common issue related party ("CIRP") group appeals for Lee Memorial Health System for calendar years ("CYs") 2008 through 2016. On April 14, 2022, the Board issued a request for additional information, as specific documents were missing from the Schedule of Providers ("SoPs") filed for each of these 9 CIRP groups. The request for documentation affected the 30-day time period as explained at 42 C.F.R. § 405.1842, which states the 30-day period for the Board to respond to an EJR request "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."[2] The updated SoPs with supporting documentation was submitted on May 23, 2022. The Board decision related to jurisdiction and EJR is set forth below.

[1] The Group Representative filed identical EJR requests in all nine of the CIRP group cases all but one EJR request were filed on March 14, 2022. Specifically, those for the cases covering CYs 2008 and 2010-2016 were filed on March 14, 2022 and the one covering CY 2009 was filed on March 30, 2022 as the group representative had "inadvertently" filed it under the wrong case number (Case No. 13-351**4**GC as opposed to 13-351**7**GC) on March 14, 2022.
[2] 42 C.F.R. § 405.1842(b)(2) (emphasis added).

I. Issue in Dispute

The Providers' Request for Hearing ("RFH") in each of these CIRP group appeals describes the issue identically, and states it as follows:

> ***Understatement of Disproportionate share ("DSH") reimbursement***
>
> The Intermediary improperly accounted for certain types of patient days in calculating the Medicare DSH adjustment. The types of days at issue include, but are not limited to, dual eligible Medicaid and Medicare Part A days, as further explained below.
>
> The Medicare DSH calculation consists of two fractions.
>
> The first fraction is known as the "Medicare fraction" or the "SSI fraction." The numerator of the Medicare fraction consists of the number of days for the period in question for which patients were entitled to both Supplemental Security Income benefits ("SSI") and Medicare Part A. The denominator of the Medicare fraction consists of the number of days for which patients were entitled to Medicare Part A benefits, regardless of whether they were also entitled to SSI benefits for those same days.
>
> The second fraction of the Medicare DSH calculation is known as the "Medicaid fraction." The numerator of the Medicaid fraction consists of the number of days for patients who were eligible for Medicaid but not entitled to Medicare Part A benefits. The denominator of the Medicaid fraction consists of the total number of patient days for the period.
>
>> **Dual eligible Medicaid and Medicare Part A days** – A patient who is a Medicare beneficiary and is also eligible for Medicaid is considered a "dual eligible" patient. Dual eligible Medicaid and Medicare Part A days include days for an inpatient stay in which such a patient is admitted without any Medicare Part A coverage and inpatient days after such a patient has exhausted his or her Medicare Part A benefits. The DSH calculation for the year at issue is calculated incorrectly because the Intermediary improperly excludes dual eligible patients from the Medicare fraction. In CMS's Ruling 1498-R, CMS indicates exhausted Medicare coverage days are eligible for Medicare benefits and thereby to be included in the Medicare fraction by

> virtue of their eligibility but only SSI days are counted. CMS draws its own distinction between eligible and entitled in its Ruling but inconsistently applies this to the Medicare factor by not including all dual eligible days. We contend all dual eligible days should be included by virtue of their benefit.
>
> Given the foregoing errors, the Intermediary's calculations were inconsistent with the Congressional intent to reimburse hospitals for treatment of all indigent patients when determining DSH program eligibility and reimbursement. The Providers are unable to determine whether the Medicare DSH payment is correct because they do not have access to all of the underlying information concerning the calculation of their payment.
>
> This appeal is not limited to challenging audit adjustments. The providers are also challenging the underlying policy of the Secretary as to the DSH calculation. Specifically, the providers are challenging the Secretary's instructions to Intermediaries to treat inpatient days of dual eligible patients that are not covered by Medicare Part A or for which the patients have exhausted their Medicare Part A benefits as days for which the patient was "entitled to Medicare Part A benefits".[3]

The Providers' EJR Requests frame the legal question for which EJR is sought as follows:

> The Group Appeal challenges the regulation and policy of the Centers for Medicare and Medicaid Services ("CMS"), promulgated as part of the FY 2005 IPPS Final Rule, to count exhausted or otherwise non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction, as adopted and applied by CMS for purposes of calculating the Hospitals' Medicare disproportionate share hospital ("<u>DSH</u>") payments during their respective fiscal years included in the Group Appeal.[4]

In addition, the Providers' EJR requests maintain that the correct treatment of no-pay Part A days in the DSH calculation (including the subset of days relating to dual eligibles) is as follows:

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[3] In each of these nine appeals, the "Group Appeal Request – Tab 2, Description of the Issue" is located in the Schedule of Providers under Global Tab B.

[4] CNs 14-0912GC, 14-4283GC, 13-3858GC, 14-4025GC, 15-3370GC, 16-2436GC, 17-2090GC, 18, 1814GC, Requests for Expedited Judicial Review ("EJR Request") at 1-2 (March 14, 2022); CN 13-3517GC, EJR Request at 2 (Mar. 30, 2022).

> Part A exhausted or noncovered days *should*, for dually-eligible patients, *be* ***included*** *in the numerator of the Medicaid fraction*, ***and excluded*** *from the Medicare/SSI fraction*, because, by definition, those days relate to patients who were not "entitled to" Medicare Part A benefits "for such days" when the services were provided. Part A exhausted days and noncovered days should be excluded from the Medicare/SSI fraction for the same reason.[5]

The Board notes that the Board has historically required the formation of two separate groups for the Dual Eligible Part A Exhausted Days issue when the appeal request for the provider(s) (whether as a group or individual appeal) includes in the requisite description of "[h]ow and why the provider believes Medicare payment must be determined differently"[6] the assertion that no-pay/exhausted Part A days must be excluded from the Medicare fraction and the subset of such days must be included in the numerator of the Medicaid fraction. Thus, when the group issue statement has included both the Medciare fraction issue and the Medciad fraction issue, the Board has required bifurcation of the two separate issues into separate groups. As detailed below in Section IV(A), the Board does not find this to be necessary in these appeals, because the Providers ***only*** appealed the exclusion of no-pay/exhausted Part A days from the Medicare fraction in their group appeal requests and, accordingly, the group appeals are limited to the single issue related to the Medicare fraction and that portion of the EJR as it relates to the Medicaid fraction is denied as it is beyond the scope of the appeals and the Board has no jurisdiction over it.

II. Statutory and Regulatory Background:

A. Adjustment for Medicare DSH

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]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[9] 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.[10]

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[5] EJR requests at 5 (emphasis added).
[6] 42 C.F.R. §§ 405.1835(b)(ii), 405.1837(c)(ii). The Board also takes administrative notice that, when processing EJR requests on these two issues, it is correcting any limited situations where the Board may have previously consolidated these two issues in error.
[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.

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, 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 & 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 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]

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[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).
[16] (Emphasis added.)
[17] 42 C.F.R. § 412.106(b)(4).

B. Accounting of Dual Eligible Days in the Medicare DSH Adjustment Calculation

In the Preamble to the FY 2004 IPPS proposed rule, published on May 19, 2003, the Secretary reiterated that the DSH patient percentage is equal to the sum of the percentage of Medicare inpatient days attributable to patients entitled to both Medicare Part A and SSI benefits, and the percentage of total inpatient days attributable to patients eligible for Medicaid but not entitled to Medicare Part A benefits.[18] The Secretary explained that, if a patient is a Medicare beneficiary who is also eligible for Medicaid, the patient is considered dual eligible. Dual eligible patient days are included in the Medicare fraction of the DSH patient percentage, but not the Medicaid fraction. The Secretary maintained that this treatment was consistent with the language of 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), which specified that patients entitled to benefits under Part A are ***excluded*** from the Medicaid fraction.[19]

At the time the proposed rule was published, the policy above applied even after the patient's Medicare coverage was exhausted. More specifically, under the policy, "if a dual-eligible patient was admitted without any Medicare Part A coverage remaining, or the patient exhausted Medicare Part A coverage while an inpatient, his or her patient days were counted in the Medicare fraction before and after Medicare coverage was exhausted."[20] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage was exhausted.[21] The Secretary then summarized his policy by stating that "our current policy regarding dual-eligible patient days is that they are counted in the Medicare fraction and excluded from the Medicaid fraction, even if the patient's Medicare Part A coverage has been exhausted."[22]

The Secretary stated that he believed that the then *current* policy regarding dual eligible patients, counting them in the Medicare fraction and excluding them from the Medicaid fraction, even if the patient's Medicare Part A coverage had been exhausted, was consistent with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II).[23] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[24] to differentiate the days for dual eligible patients whose Part A coverage has been exhausted. The Secretary explained that the degree of difficulty in differentiating the days varied from State to State depending on whether the States identified dual eligible beneficiaries in their list of Medicaid patient days provided to hospitals or whether the MACs or hospitals had to undertake the identifications. Underlying the Secretary's concern was the fact that there were hospitals located in States where no Part A bill may be submitted for the

[18] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.* at 27207-27208.
[23] *Id.* at 27207-27208.
[24] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.

beneficiaries with exhausted Medicare Part A coverage. Consequently, the MACs had no data by which to verify any adjustment for these cases in the Medicaid data furnished by the hospital.[25]

In light of these concerns and to facilitate consistent handling of these days across all hospitals, the Secretary proposed in the FY 2004 IPPS proposed rule to change this policy and that the days of patients who have exhausted their Medicare Part A coverage would no longer be included in the Medicare fraction and, instead, would be included in the Medicaid fraction of the DSH calculation.[26] The Secretary noted that not all SSI recipients are Medicaid eligible and, therefore, it would not be automatic that the patient days of SSI recipients would be counted in the Medicaid fraction when their Part A coverage ended.[27] Under the proposed change, before a hospital could count patient days attributable to dual eligible beneficiaries in the Medicaid fraction, the hospital would be required to submit documentation to the MAC that justified including the days in the Medicaid fraction after Medicare Part A benefits had been exhausted.[28]

However, when the Secretary published the FY 2004 IPPS final rule on August 1, 2003, the Secretary did not adopt and finalize the proposed policy changes regarding dual eligible days.[29] Rather, he stated that "[d]ue to the number and nature of the comments we received on our proposed policies, we are addressing the public comments in a separate document."[30]

On May 18, 2004, the Secretary provided an update. Specifically, in the preamble to the FY 2005 IPPS proposed rule published on that date, the Secretary stated that the Secretary planned to address the proposed policy changes regarding dual eligible days in the forthcoming FY 2005 IPPS final rule.[31] In the preamble to the FY 2005 IPPS final rule published on August 11, 2004, the Secretary addresses the previously proposed policy changes and recognized that it has "inadvertently misstated" its then current policy on the treatment of dual-eligible patients in the calculation of DSH adjustments. Specifically, the Secretary stated:

> It has come to our attention that we inadvertently *misstated* our ***current*** policy with regard to the treatment of certain inpatient days for dual-eligibles in the proposed rule of May 19, 2003…In that proposed rule, we indicated that a dual-eligible beneficiary is included in the Medicare fraction even after the patient's Medicare Part A hospital coverage is exhausted. That is, we stated that if a dual-eligible patient is admitted without without any Medicare Part A hospital coverage remaining, or the patient exhausts Medicare Part A hospital coverage while an inpatient, the non-covered patient daysare counted in the Medicare fraction.

[25] 68 Fed. Reg. at 27208.
[26] *Id.*
[27] *Id.*
[28] *Id.*
[29] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[30] *Id.*
[31] 68 Fed. Reg. 28196, 28286 (May 18, 2004).

> This statement was not accurate. ***Our policy has been*** that only ***covered*** patient days are included in the Medicare fraction (§ 412.106(b)(2)(i)). A notice to this effect was posted on CMS's Web site (*http://www.cms.hhs.gov/providers/hipps/dual.asp*) on July 9, 2004.[32]
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> ****
>
> [W]e have decided ***not*** to finalize our proposal stated in the May 19, 2003 proposed rule to include dual-eligible beneficiaries who have exhausted their Part A hospital coverage in the Medicaid fraction. Instead, ***we are adopting a policy*** *to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage.* If the patient is entitled to Medicare Part A and SSI, the patient days will be included in both the numerator and denominator of the Medicare fraction. This policy will be effective for discharges occurring on or after October 1, 2004. *We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with dual eligible beneficiaries* ***in the Medicare fraction*** *of the DSH calculation*.[33]

Accordingly, the Secretary adopted a *new* policy to "include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[34] In order to effectuate this policy change, the FY 2005 IPPS final rule revised 42 C.F.R. § 412.106(b)(2)(i) by deleting the word "covered."[35] Prior to this revision, § 412.106(b)(2) (2004) had stated:

> (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* ***covered*** *patient days that—*
>
> (A) Are associated with discharges occurring during each month; and

[32] 69 Fed. Reg. 48916, 49098 (Aug. 11, 2004)(emphasis added).
[33] *Id.* at 49099 (emphasis added).
[34] *Id.*
[35] *See id.* at 49099, 49246.

> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[36]

As a result of the revision made by the FY 2005 IPPS final rule, § 412.105(b)(2)(i) (2005) now states:

> (2) First computation: Federal fiscal year. For each month of the Federal fiscal year in which the hospital's cost reporting period begins, CMS—
>
> (i) *determines the number of patient days that*--
>
> (A) Are associated with discharges occurring during each month; and
>
> (B) Are furnished to patients who during that month were entitled to both Medicare Part A and SSI, excluding those patients who received only State supplementation . . .[37]

Again, the effect of this change was to adopt "a policy to include the days associated with dual-eligible beneficiaries in the Medicare fraction, whether or not the beneficiary has exhausted Medicare Part A hospital coverage."[38]

Dropping the word "covered" from § 412.105(b)(2)(i) also had the effect of including any no-pay Part A days (including when the underlying patient was not Medicaid eligible) in the Medicare fraction.[39] This is highlighted in CMS Ruling 1498-R as follows:

> [T]he FY 2005 final rule amended the DSH regulation by eliminating the requirement that Part A inpatient hospital days must be covered in order for such days to be included in the SSI fraction…*Under our **revised** policy*, the inpatient days of a person who was entitled to Medicare Part A are included in the numerator of the hospital's DSH SSI fraction (provided that the patient was also entitled to SSI) and in the SSI fraction denominator, regardless of whether the individual's inpatient hospital stay was covered under Part A or whether the patient's Part A hospital

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[36] (Emphasis added.)
[37] (Emphasis added.)
[38] *Id.*
[39] If the underlying patient had SSI, then those no-pay Part A days are included in both the numerator and denominator of the Medicare fraction. If the underlying patient did not have SSI, then those no-pay Part A days are only included in the denominator of the Medicare fraction. This treatment occurs regardless of whether the underlying patient was also Medicaid eligible on the days in question (*i.e.,* was a dual eligible).

> benefits were exhausted. (We note that, as a practical matter, an inpatient hospital day for a person entitled to Medicare Part A, including an individual enrolled in Part C, will be included in the SSI fraction only if the individual is enrolled in Part A or Part C and the hospital has submitted a Medicare claim on behalf of the patient.) The FY 2005 amendment to the DSH regulation was effective for cost reports with patient discharges on or after October 1, 2004.[40]

The Board notes that several court cases have reviewed the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i). In the first case, *Stringfellow Mem'l Hosp. v. Azar* ("*Stringfellow*"),[41] the U.S. District Court for the District of Columbia ("D.C. District Court") considered whether the FY 2005 IPPS final rule violated the Administrative Procedure Act ("APA") because the rule is procedurally defective and arbitrary and capricious.[42] The D.C. District Court concluded that the Secretary promulgated FY 2005 IPPS final rule with adequate notice and comment procedures and that the rule is *not* procedurally defective.[43] Further, the D.C. District Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[44] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit"); however, the D.C. Circuit later dismissed it.[45] Accordingly, the D.C. District Court's decision to uphold the FY 2005 change to 42 C.F.R. § 412.106(b)(2)(i) was not otherwise altered.

In the second case, *Catholic Health Initiatives Iowa Corp. v. Sebelius* ("*Catholic Health*"),[46] the D.C. Circuit reviewed the agency's interpretation of the phrase "entitled to benefits" as used in 42 U.S.C. § 1395ww(d)(5)(F)(vi) and, consistent with its 2011 decision in *Northeast Hospital Corp v. Sebelius*,[47] found that the Secretary's interpretation that that an individual is "entitled to benefits" under Medicare when he meets the basic statutory criteria for Medicare Part A was a reasonable and permissible interpretation of that phrase.[48]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[49] the U.S. District Court for the Eastern District of Washington ("Washington District Court") reviewed the question of "the validity" of the Secretary's FY 2005 IPPS final rule with regard to the Secretary's interpretation of the phrase "entitled to benefits under [Medicare Part A] in 42 U.S.C. § 1395ww."[50] In *Empire*, the hospital had alleged that the FY 2005 IPPS final rule amending 42 C.F.R.

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[40] (Citations omitted and emphasis added.)
[41] 317 F. Supp. 3d 168 (D.D.C. 2018).
[42] *Id.* at 172.
[43] *Id.* at 190.
[44] *Id.* at 194.
[45] *See* 2019 WL 668282.
[46] 718 F.3d 914 (2013).
[47] 657 F.3d 1 (D.C. Cir. 2011).
[48] 718 F.3d at 920.
[49] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[50] *Id.* at 1141.

§ 412.106(b)(2) was substantively and procedurally invalid.[51] The Washington District Court noted that the Secretary misstated the then-existing policy until approximately three days before the close of the comment period for the FY 2005 IPPS proposed rule and that the inaccuracy of the policy statement necessarily distorted the context of the proposed rule. The Washington District Court determined that, without an accurate context in which to view the Secretary's proposed rule, interested parties cannot know what to expect and have no basis on which to make comments. Further, the Washington District Court pointed out that interested parties could not have reasonably anticipated the Secretary's rulemaking contained a misstatement. Consequently, the Washington District Court found that the Secretary's notice failed to satisfy the procedural rulemaking requirements of the APA[52] and that the regulation is procedurally invalid.[53]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[54] and reversed that Court's finding that the revision made by the FY 2005 IPPS Final Rule to 42 C.F.R. § 412.106(b)(2)(i) failed to satisfy the procedural rulemaking requirements of the APA.[55] Rather, the Ninth Circuit found that this revision "was a logical outgrowth of the notice and the comments received" and that it "met the APA's procedural requirements."[56] However, the Ninth Circuit then reviewed substantive validity of this revision and determined that it was bound by the previous Ninth Circuit's 1996 decision in *Legacy Emanuel Hospital and Health Center v. Shalala* ("*Legacy Emanuel*")[57] wherein the Ninth Circuit considered the meaning of the words "entitled" and eligible in tandem as those words are used in the statutory description of the Medicaid fraction at 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II). Specifically, in *Legacy Emanuel*, the Ninth Circuit "interpreted the word 'entitled' to mean that a patient has an 'absolute right . . . to payment'" and "the word 'eligible' to mean that a patient simply meets the Medicaid statutory criteria."[58] In *Empire*, the Ninth Circuit noted that, in the FY 2005 IPPS Final Rule, the Secretary adopted a different meaning to "entitled" that more closely aligned with the meaning of the word "eligible."[59] According, in *Empire*, the Ninth Circuit held that "[b]ecause we have already construed the unambiguous meaning of 'entitled' to [Medicare]" in 42 U.S.C. § 1395(d)(5)(F)(vi), we hold that the [FY 2005 IPPS Final Rule's] contrary interpretation of that phrase is substantively invalid pursuant to APA."[60] Accordingly, the Ninth Circuit took the following actions to implement its holding:

1. It affirmed the Washington District Court's order vacating the FY 2005 IPPS Final Rule as it relates to the deletion of the word "covered" from 42 C.F.R. § 412.106(b)(2)(i); and

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[51] *Id.*
[52] *Id. at 1162*.
[53] *Id. at 1163*
[54] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[55] *Id.* at 884.
[56] *Id.* at 884.
[57] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[58] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[59] *Id.* at 886.
[60] *Id.*

2. It "reinstat[ed] 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).

The Secretary appealed the Ninth Circuit decision and the case is currently pending before the U.S. Supreme Court.[61] Thus, as of the date of this decision, the Secretary's position with respect to the validity of the regulation at 42 C.F.R. § 412.106(b)(2)(i) (as modified by the FY 2005 IPPS Final Rule) has not changed.

III. Providers' Position in EJR Requests

In their EJR requests, the Providers contend the Board lacks the authority to decide whether CMS' regulation and policy for counting exhausted or noncovered days for Medicare Part A patients in the DSH fractions are valid. The Providers state that CMS policy has been inconsistent regarding the treatment of the days at issue, and that for twenty years CMS did not count Part A exhausted and non-covered days in the DSH Medicare/SSI fraction. Then in the FY 2004 IPPS Proposed Rule, CMS proposed to permit providers to count exhausted and non-covered Part A patient days in the numerator of the Medicaid fraction for patients that were dually-eligible. This 2004 proposal was not enacted, and then in the FY 2005 IPPS Proposed Rule CMS again proposed counting exhausted and non-covered Part A patient days in the Medicaid fraction. However, in the FY 2005 IPPS Final Rule, CMS finalized the ***opposite*** policy from what it proposed, reversing a long-standing policy.

The Providers allege that CMS' decision to count exhausted and non-covered Part A patient days in the Medicare/SSI fraction, and exclude such days from the dual-eligible days that were previously included in the Medicaid fraction numbers, was a policy change that decreased providers DSH payments from FY 2005 forward. The Providers claim this policy and regulation are substantively and/or procedurally invalid because the days at issue relate to patients who were not "entitled to" Medicare Part A benefits "for such day" when the services were provided. Thus, Part A exhausted and noncovered days should be excluded from the Medicare/SSI fraction and included in the Medicaid fraction.

The Providers argue that CMS' 2005 rulemaking was flawed because of misstated current and proposed policies, as well as inadequate explanation for the chosen policy. The Providers assert the resulting policy is due no deference as CMS violated the APA by not providing adequate notice and opportunity for comment in promulgating the 2005 Final IPPS Rule. The Providers allege CMS' interpretation of the phrase "entitled to benefits under [Medicare Part A]" for purposes of the DSH calculation is inconsistent with the statute, precedent, and is arbitrary and capricious. The Providers cite to *Empire Health Fdn. v. Azar*, 958 F.3d 873 (9th Cir. 2020) in support of their position.

The Providers indicate that CMS' policy and regulation requiring Part A exhausted and noncovered days to be counted in the DSH Medicare/SSI fraction (and excluding these days

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[61] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

from the Medicaid fraction for dually-eligible patients) are substantively and/or procedurally invalid. Because the Board lacks the authority to determine whether the policy and regulation are invalid, the Providers seek expedited judicial review over this legal question.

IV. 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.

A. The Board Lacks Jurisdiction over the 9 CIRP Groups.

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 must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination;[62]
- The matter at issue involves ***single*** question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and
- The amount in controversy is, in the aggregate, $50,000 or more.[63]

For an issue to be added to an existing appeal, the request for addition must comply with the same requirements for requesting a Board hearing in an initial appeal.[64] When the underlying individual appeals were filed, the Board Rules (Mar. 1, 2013) required Providers to, for each issue under appeal, provide the basis for dissatisfaction with its final determination. With regard to identifying the issue, Board Rules required Providers to include an issue statement in the appeal request that described the adjustment, why the adjustment was incorrect, and how the payment should be determined differently.[65] Similarly, the regulation at 42 C.F.R. § 405.1835(b) (2013) stated:

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[62] 42 U.S.C. § 1395oo(a)(1)(A)(i); see also Washington Hosp. Ctr. v. Bowen, 795 F.2d 139, 144-145 (D.C. Cir. 1986).
[63] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840
[64] 42 C.F.R. § 405.1835(e).
[65] PRRB Rule 7 (Mar. 1, 2013) (emphasis added). See also Board Rule 8 (stating "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and described as narrowly as possible using the applicable format outlined in Rule 7." (emphasis added)).

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

Failure to meet these requirements permits the Board to dismiss the issue with prejudice or take any other remedial action it considers appropriate.[66] A request to add an additional issue is timely made if received by the Board no later than 240 days after the date of a final determination.[67]

The requirements for establishing a group appeal are similar. In this regard, 42 C.F.R. § 405.1837(c) (2014) addresses the content of a group appeal request:

> (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:

[66] 42 C.F.R. § 405.1835(b).
[67] 0 42 C.F.R. § 405.1835(c)(3) (2013).

> (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.
>
> (2) An explanation (for each specific item at issue; see §405.1835(a)(1)) of each provider's dissatisfaction with its 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, a description of the nature and amount of each self-disallowed item and the reimbursement sought for each item.
>
> (3) A copy of each contractor or Secretary determination under appeal, and any other documentary evidence the providers consider necessary to satisfy the hearing request requirements of paragraphs (c)(1) and (c)(2) 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 matters at issue in the group appeal; and
>
> (4) A statement that—
>
> (i) The providers believe they have satisfied all of the requirements for a group appeal hearing request under paragraph (a) of this section and requesting the Board to proceed to make jurisdictional findings in accordance with §405.1840; or
>
> (ii) The Board is requested to defer making jurisdictional findings until the providers request the findings in accordance with paragraph (e)(2) of this section.

The Board finds that the group issue statement for each of the 9 CIRP groups contained two separate legal issues. As set forth below, the Board find that the first issue was abandoned and that the Providers failed to establish the Board's jurisdiction over the second issue.

1. *The first and primary issue of the group has been abandoned and, as such, it was effectively withdrawn and is no longer pending in these cases*.

The first issue concerns the Providers desire to ***add*** certain dual eligible days to the ***Medicare*** fraction. Specifically, each of the group issues statements filed with the group appeal request for each of the 9 CIRP groups contains the following issue:

> The DSH calculation for the year at issue is calculated incorrectly because the Intermediary *improperly* ***excludes*** *dual eligible patients* ***from the Medicare fraction***. In CMS's Ruling 1498-R, CMS indicates exhausted Medicare coverage days are eligible for Medicare benefits and thereby to be included in the Medicare fraction by virtue of their eligibility but only SSI days are counted. CMS draws its own distinction between eligible and entitled in its Ruling but inconsistently applies this *to the Medicare factor* ***by not including all dual eligible days***. *We contend all dual eligible days should be* ***included*** by virtue of their benefit.

This first issue (as quoted above) is clearly not the issue for which EJR is request because it is seeking to ***add*** certain dual eligible days to the Medicare fraction as opposed to the issue raised in EJR request seeking to ***exclude*** no-pay/exhausted Part A days from the Medicare fraction.

Indeed, it appears that this first issue may be similar the one raised in PRRB Dec. No. 2017-D11 (March 17, 2017) where the providers asserted that the phrase "entitled to [SSI] benefits"[68] should be expanded from meaning payment of SSI cash benefits (as exemplified by SSI codes M01, M02 & C01) to eligible for SSI benefits. Consistent with that proposition, the impact statements for each of the providers *used to form each of these groups*[69] reflected the ***addition*** of SSI days to the numerator of the SSI fraction (see the example used below). However, the Board need not decide exactly what this issue encompassed because it is clear that the Providers ***abandoned*** this first issue as demonstrated by the following facts:

(1) Per 42. C.F.R. § 405.1837(a), in order for a provider to have a right to a group hearing, there may only be ***one*** issue in the group (not two or more):

> (a) *Right to Board hearing as part of a group appeal*: *Criteria*. A provider (but no other individual, entity, or party) has a right to a Board hearing, **as part of a group appeal with other providers**, with respect to a final contractor or Secretary determination for the provider's cost reporting period, **only if**—

[68] 42 U.S.C. § 1395w2(d)(5)(F)(vi)(I). *See also* 42 C.F.R. § 412.106(b)(2)(i)(B).
[69] 42 C.F.R. § 405.1837(b)(3) specifies that, in order to form or establish a CIRP group, there must be at least one founding participant. The CIRP group for CY 2009 had only one founding participant. Each of the CIRP groups for CYs 2008 and 2010 had 2 founding participants. Finally, each of the CIRP groups for CYs 2011-2016 had 3 founding participants.

> (1) The provider satisfies individually the requirements for a Board hearing under §405.1835(a) or §405.1835(c), except for the $10,000 amount in controversy requirement in §405.1835(a)(2) or §405.1835(c)(3).
>
> (2) **The matter at issue <u>in the group appeal</u> involves a <u>single</u> question of** fact or **interpretation of law, regulations**, or CMS Rulings that is common to each provider in the group; and
>
> (3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with §405.1839 of this subpart.[70]

(2) The EJR requests filed in the 9 CIRP groups make clear that "*[t]he **<u>sole</u>** issue in dispute* is the substantive and/or procedural validity of CMS's policy and regulation to count Part A exhausted and non-covered days for patients eligible for Medicare in the Medicare/SSI fraction and not, where the patient is dually eligible for Medicaid, in the Medicaid fraction."[71] As a result, the Providers are representing that no other issues remained.

(3) The Providers assert in their EJR request that the Board has jurisdiction over the group ***and***, as noted in (1) above, a requisite part of the Board's jurisdiction over a group (*i.e.*, a provider's right to be part of a group) is that there be only ***one*** issue in that group.[72]

(4) The Board finding of jurisdiction over the group is a prerequisite to granting EJR as explained at 42 C.F.R. § 405.1842(b)(1):

> (b) *General*—(1) ***<u>Prerequisite</u> of Board jurisdiction***. The Board (or the Administrator) **must find that the Board has jurisdiction**

[70] (Bold and underline emphasis added.)

[71] In addition, in some cases, the Providers have filed preliminary position papers ("PPPs") in their group case and failed to brief this issue (*e.g.*, Case No. 18-1814GC. As an alternative basis, the Board could review the PPPs filed in any of these 9 cases to determine if the first issue had been abandoned even earlier at the position paper/briefing stage. In this regard, the Board notes that Board Rule 25.3 (Nov. 1, 2021) states: "The Board requires the parties file a complete preliminary position paper that includes a fully developed narrative (Rule 25.1), all exhibits (Rule 25.2), 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. If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Similarly, Board Rule 25.3 (Aug. 29, 2018) stated: "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."

[72] 42 C.F.R. §§ 405.1840, 405.1837(a). *See also* 42 C.F.R. § 405.1837(f) (stating "The Board may not consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal.")

> over the specific matter at issue ***before*** the Board may determine its authority to decide the legal question.

Accordingly, based on the EJR requests filed in each case, the Board finds that this first issue was abandoned as part of the group appeals[73] and, as such, this first issue was effectively withdrawn from the appeal and is no longer pending in any of the 9 CIRP groups.[74]

2. *The Providers have failed to establish the Board's jurisdiction over the sole remaining second issue in the 9 CIRP groups and, as such, the Board must dismiss these groups and deny EJR.*

In the last paragraph of the group issue statements filed as part of the initial group appeal request for the 9 CIRP groups, the Providers include a second issue challenging a policy of the Secretary:

> This appeal is not limited to challenging audit adjustments. The providers are also challenging the underlying policy of the Secretary as to the DSH calculation. *Specifically, the providers are **challenging** the Secretary's **instructions*** to Intermediaries *to treat inpatient days of dual eligible patients that are not covered* by Medicare Part A or for which the patients have exhausted their Medicare Part A benefits *as days for which the patient was* "*entitled to Medicare Part A benefits*".[75]

Thus, the Providers appear to be challenging the policy in the FY 2005 IPPS Final Rule to include no-pay/exhausted dual eligible days in the Medicare fraction. However, the issues statement does not explicitly state "how . . . the provider believes Medicare payment must be determined differently" as required by 42 C.F.R. §§ 405.1835(b)(ii) and 405.1837(c)(2)(ii). As explained below, the Providers have failed to cure the fatal defect and it results in a failure of the Providers to establish the Board's jurisdiction over these 9 CIRP groups and the underlying participants.

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[73] If the Board had not found that the Providers had abandoned the first issue, then 42 C.F.R. § 405.1837(f)(2) would have been applicable:

> (2) The Board *may **not** consider*, in one group appeal, *more than **one** question* of fact, interpretation of law, regulations, or CMS Rulings that is common to each provider in the appeal. If the Board finds jurisdiction over a group appeal hearing request under §405.1840 of this subpart—
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question ***common** to **each** provider*; and
> (ii) When the appeal is found to involve more than one factual or legal question ***common** to **each** provider*, the Board must assign a separate case number to the appeal of each common factual or legal question and conduct further proceedings in the various appeals separately for each case.

[74] This is also analogous to Board Rule Board Rule 25.3 which states that, if an issue is not brief in a position paper, then it is effectively withdrawn. *See supra* note 71 (containing a quotation of this Rule).

[75] (Emphasis is added.)

i. *This second issue can **only** relate to the **Medicare** fraction because the reversal of the challenged policy would not automatically mean that days get shifted to the Medicaid fraction.*

Contrary to the Providers' assertion ***in their EJR requests***, the invalidation of the policy adopted in the FY 2005 IPPS Final Rule mandating that no-pay/exhausted Part A days be counted in the Medicare fraction does not *automatically* mean that the subset of those days pertaining to dual eligible will be counted in the numerator of the Medicaid fraction. As evidenced, by the 9th Circuit's decision in *Empire*, the invalidation of the DSH no-pay Part A days policy (as finalized in the FY 2005 IPPS Final Rule) does not *automatically* result in no-pay Part A days involving Medicaid eligible patients being counted in the Medicaid fraction. In this regard, the Board notes that the 9th Circuit's decision in *Empire* only reinstated the prior version of 42 C.F.R. § 412.106(b)(2)(i) under which no-pay Part A days were counted in neither the Medicare fraction nor the Medicaid fraction.

Moreover, it is clear that the situation in the instant case is not as simple as the one presented in *Allina Health Servs. v. Sebelius* ("*Allina*").[76] In *Allina*, the 9th Circuit reviewed how the whole class of patients who were enrolled in Medicare Part C should be treated under the DSH statute. Specifically, the D.C. Circuit in Allina stated: "the statute ***unambiguously*** requires that Part C days be counted in one fraction or the other (a Part C-enrolled individua l is either eligible for Medicare Part A, or not)."[77]

In contrast, the EJR requests filed for these 9 CIRP groups involve no-pay Part A days and the subset of no-pay Part A days associated with dual eligibles. It is clear that the *class of patients* who are dually eligible do, in fact, have Medicare Part A (*i.e.*, they are enrolled in Medicare Part A) and that, with respect to this *patient class*, any days associated with Medicare Part A beneficiaries may not be excluded *in toto* from the Medicare fraction and included in the Medicaid fraction (*i.e.*, it is undisputed that some dual eligible patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits).[78] To this end, the Providers' ***EJR requests*** are asserting that only in *certain* ***no-pay*** Part A situations that involve a dual eligible beneficiary (*e.g.*, exhausted benefits and MSP) must the days associated with this class of patients be excluded from the SSI fraction and included in the Medicaid fraction.

Similarly, the class of patients who have Medicare Part A includes dual eligibles and that, with respect to this larger patient class, any days associated with them may not be excluded *in toto* (*i.e.*, it is undisputed that some Part A patients have days ***paid*** or covered under the Medicare Part A and were otherwise "entitled" to Part A benefits). Significantly, under the Providers' desired interpretation of the DSH statute (*as stated in the EJR requests*), any days associated with no-

[76] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[77] *Id.* (emphasis is added).
[78] This is different than Part C days where, ***as a class of days***, Part C days must be counted in either the SSI fraction or the Medicaid fraction. As explained in the 2014 holding of the D.C. Circuit in *Allina Health Servs. v. Sebelius* ("*Allina*"), the DSH statute at 42 U.S.C. § 1395ww(d)(5)(F)(vi) "*unambiguously requires*" that Part C days be included in either the SSI fraction or Medicaid fraction. 746 F.3d 1102, 1108 (D.C. Cir. 2014).

Pay Part A days for which the beneficiary was *not* Medicaid eligible (*i.e.*, the patient was not a dual eligible) would not be counted in either the Medicare or Medicaid fraction.

Accordingly, the Board disagrees with the Providers' assertion ***in their EJR requests*** that exclusion of days associated with no-pay Part A situations where the underlying patient is a dual eligible *automatically* means such days must be counted in the Medicaid fraction. In further support of its position, the Board refers to: (1) the D.C. Circuit's 2013 decision in *Catholic Health Initiatives v. Sebelius* ("*Catholic Health*");[79] and (2) CMS Ruling 1498-R2, wherein multiple possible treatments of no-pay dual eligible days are discussed and wherein CMS reconfirms that its policy prior to October 1, 2004 was to exclude all no-pay Part A days from the Medicare and Medicaid fractions even where the underlying patient was also eligible for Medicaid, stating:

> Under our *original* DSH policy, inpatient days were included in the numerator of the Medicare-SSI fraction only if the inpatient hospital days were "covered" under Medicare Part A and the patient was entitled to SSI benefits; Part A coverage of inpatient days alone was required for inclusion in the denominator of the Medicare-SSI fraction. (See, for example, 42 CFR 412.106(b)(2)(i) (2003).) Our *original* policy further provided that non-covered inpatient hospital days of patients entitled to Medicare Part A, including days for which the patient's Part A inpatient hospital benefits were exhausted, were ***excluded*** from the numerator of the Medicaid fraction (even when the patient was eligible for Medicaid), but such non-covered or exhausted benefit inpatient hospital days were included in the Medicaid fraction denominator (to the extent that the hospital reported such days on its Medicare cost report). See the August 11, 2004 final rule entitled Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2005 Rates (FY 2005 IPPS final rule) (69 FR 48916 and 49098).[80]

Indeed, the relief requested by the Providers ***in their EJR requests*** was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[81] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire* ***and*** the Board were to grant the EJR request without modification (which it is not), the Providers would be arguing that the CMS' prior policy of excluding from the Medicaid fraction any no-pay Part A days involving patients who were also Medicaid eligible is also invalid.[82]

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[79] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients.
[80] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[81] *See Edgewater Med. Ctr. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (June 6, 2000), *affirming*, PRRB Dec. Nos. 2000-D44, 2000-D45 (Apr. 7, 2000). *See also* 718 F.3d at 918, 921-22 (D.C. Circuit in *Catholic Health* discussing the Administrator's *Edgewater* decision and explaining that "the policy of excluding dual-eligible exhausted days from the Medicaid fraction was announced four years earlier in *Edgewater*").
[82] *See also* the Board's discussion of *Empire* at the end of Section II(B). The Board further notes that the Providers recognize in their EJR requests at page 4 that: "For roughly 20 years, CMS did not count Part A exhausted and non-

Accordingly, the Board maintains that the invalidation of the policy stated would not automatically result in the Medicaid fraction being impact. Thus, it is clear that the portion of the EJR request pertaining to the Medicaid fraction (*i.e*, requesting that no-pay/exhausted Part A days involving dual eligible be included in the numerator of the Medicaid fraction) is beyond the scope of the group issue statement filed in each of these 9 CIRP groups.[83] Again, the Providers' failed to include a statement of "how . . . the provider believes Medicare payment must be determined differently" as required by 42 C.F.R. §§ 405.1835(b)(ii) and 405.1837(c)(2)(ii)." As a result, ***at best***, the Board could only presume that, in these group issue statements, the Providers were requesting that the challenged policy be invalidated in order to return to the prior policy that excluded all no-pay Part A days (including those associated with dual eligibles) from both the Medicare and Medicaid fractions.

While the Board has resolved this issue, it is inconsequential because, as set forth below, the Providers have failed to establish ***any*** amount in controversy for this second issue (whether it is limited to exclusion of no-pay/exhausted Part A days from the Medicare fraction or whether it is expanded to include the addition of the subset of those days pertaining to dual eligible to the numerator of the Medicaid fraction).

ii. *The Board lacks jurisdiction over these 9 CIRP groups and the underlying participants as the Providers have failed to establish any amount in controversy for each of the CIRP groups as a whole or any of the individual participants* ***as it relates to the second issue (the sole remaining issue in these groups)***.

The impact calculation for the provider(s) used to form each of these 9 CIRP groups failed to shed any light on this deficiency noted above, namely the failure of the Providers to describe in their group issue statement used to establish each of the 9 CIRP groups "how . . . the provider believes Medicare payment must be determined differently" as required by 42 C.F.R. §§ 405.1835(b)(ii) and 405.1837(c)(2)(ii). In particular, the impact calculation did ***not remove <u>any</u>*** *days from the* ***Medicare*** *fraction* (whether from the numerator or the denominator of the Medicare fraction) ***and*** did not include ***any*** adjustment to the numerator of the Medicaid fraction. Thus, the impact calculations for each of the founding participants used to form/establish the 9 CIRP groups did not include or reflect the second issue and, as such, cannot be used to cure the fatal deficiency.

covered days in the Medicare/SSI fraction. Then, in its FY 2004 IPPS Proposed Rule, CMS proposed to permit hospitals to count Part A exhausted and non-covered days in the numerator of the Medicaid fraction for patient who were dually-eligible. 68 Fed. Reg. 27,154, 27,208 (May 19, 2003)."

[83] The Board also notes that 42 C.F.R. § 405.1837(f)(1) makes clear that issues may not be added to a group appeal after the group hearing request is filed. As such, the Board finds that it lacks jurisdiction over the *<u>Medicaid fraction portion</u>* of this EJR Request because that issue was not included in the original appeals, and, since jurisdiction is a prerequisite to granting EJR, the Board must deny that portion of the EJR Request pertaining to inclusion of no-pay/exhausted dual eligible days in the numerator of the *<u>Medicaid fraction</u>*.

To illustrate, the Board has included the following impact statement of the sole provider used to establish Case No. 13-3517GC:

Operating [DSH]	As Adjusted	Computation for Dual Eligible Days
Medicaid Fraction Calculation		
Total Non-Exempt PPS Medicaid Eligible Days	13,401	13,401
Add: Protested Medicaid Days	-	-
Total Adjusted Non-Exempt PPS Medicaid Eligible Days	13,401	13,401
Total Non-Exempt PPS Patient Days	94,264	94,264
Medicaid Utilization Percentage	14.22%	14.22%
Medicare Fraction Calculation		
Published SSI Days	2,746	2,746
Add: Additional SSI Days	-	10,902
Adjusted SSI Days	2,746	13,648
Published Total Medicare Days	55,677	55,677
Less: Total Medicare Days Reduction	-	-
Adjusted Total Medicare Days	55,677	55,677
2007 Published SSI% Per CMS/Recalculated SSI%	4.93%	24.51%
Total DSH Percentage	19.15%	38.73%

The impact calculation then plugged each of these total DSH percentages into the DSH adjustment calculation and then identified the differential of $10,559,706 as the estimated amount in controversy for this provider. Significantly, this impact calculation does not *remove* ***any*** days from the ***Medicare*** fraction, notwithstanding that it has an *empty* line to remove days from the denominator of the Medicare fraction entitled "Less: Total Medicare Days Reduction." This exact same format and information was used for every single provider used to establish these 9 groups and, in every single case, there was no removal of day from the Medicare fraction and no addition of days to the Medicaid fraction. Accordingly, the Providers failed to file a proper group appeal on this second issue.[84]

Notwithstanding, the Providers failed to correct this fatal flaw[85] when they filed their final SoP for each case and included behind Tab E for each provider an impact calculation. Specifically,

[84] The Board notes that, when a group issue statement has some ambiguity, clarity may be gained by looking at the impact calculation associated with that issue for the ***founding*** participant(s) of that group. Only the founding members are reviewed since they were filed simultaneously with the group appeal request and since 42 C.F.R. § 405.1842(f)(1) specifies that no issues may be added to a group once it is filed. Here, the impact calculation of the founding participant(s) for the 9 CIRP groups do not provide any clarity around the second issue and, in fact, do not even address the second issue.
[85] The Board need not determine whether the flaw was able to be rehabilitated since the Providers never recognized it and corrected it in the filing of the final SoPs and EJR requests.

for each provider in all of the 9 CIRP groups, Tab E has the ***exact same*** format and information and, in every single case, there was ***no*** removal of days from the Medicare fraction (whether from the numerator or denominator) *and* ***no*** addition of days to the Medicaid fraction. Board Rules specify the SoPs must include all documentation necessary to establish jurisdiction for each provider in the appeal as denoted by the following excerpts from the Board Rules (Nov. 1, 2021):

- Board Rule 20.1.1—"[W]ithin 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)."[86]

- Commentary to Board Rule 20.1.3— "The schedule of providers is designed to assemble various elements of documentation to demonstrate that the Board has jurisdiction over each provider to be included in the group. Because some groups include numerous, even hundreds, of providers, a uniform format is essential to manage the documentation.

  "The Model Form G – Schedule of Providers (Appendix G) is included to assist in this process. To this end, it is the responsibility of the group representative to gather these data elements and supporting documentation for each provider to be included in the group, even when such documentation may be on file with the Board in another appeal (*e.g.*, the underlying individual appeal, another group appeal). **Failure to submit the requisite documentation for one of the providers may result in the dismissal of that provider from the group**."[87]

- Board Rule 21.6 entitled "Amount in Controversy"—

  "**21.6.1 Schedule – Column E**
  Identify the amount in controversy (reimbursement effect). (*See* Rule 6.4.)

  "**21.6.2 Documentation – Tab E**
  Provide a calculation if the reimbursement effect is different from the audit adjustment."

- Board Rule 6.4 entitled "Amount in Controversy" stating, in pertinent part, that "[a] calculation of the amount in controvery with supporting documentation must be provided for ***each*** issue."[88]

Further, the Board notes that 42 C.F.R. § 405.1839 addresses the amount in controversy and states in pertinent part:

[86] (Emphasis added.)
[87] (Bold and underline emphasis added.)
[88] (Emphasis in original.)

> (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).

Accordingly, by not including an impact calculation for the second issue for each Provider participating in the 9 CIRP groups, the Providers have failed to establish that each of the 9 CIRP groups met the minimum $50,000 amount in controversy.

Not only did the Providers fail to demonstrate in the group appeal request for each of the 9 CIRP group "how . . . the provider believes Medicare payment must be determined differently" as required by 42 C.F.R. §§ 405.1835(b)(ii) and 405.1837(c)(2)(ii), but they also failed to demonstrate that the amount in controversy for each CIRP group is, in the aggregate, $50,000 or more. Indeed, no participant even meets the minimum $10,000 amount in controversy because none of the participants on the 9 CIRP groups have an impact calculation on this second issue.

In this regard, the Board recognizes that the EJR request filed in each case asserts on page 7 that "[t]he amount in controversy for the Group Appeal is also well in excess of the jurisdictional minimum of $50,000" and in support cites the "Jurisdictional Documents, Tabs E." However, a group appeal can only have one group issue and the participants in that group must in the aggregate meet the minimum $50,000 amount in controversy for the single issue. Here, the impact calculations ***only*** pertain to the first abandoned issue. Had the Providers not abandoned that first issue in each of the 9 CIRP groups, the Board would have had to bifurcate it pursuant to 42 C.F.R. § 405.1837(f)(2)(ii) and those impact calculations would only pertain to the bifurcated cases. Indeed, 42 C.F.R. § 405.1839(b)(2)(i) makes clear that "[f]or purposes of satisfying the amount in controversy requirement, group members are ***not*** *allowed to aggregate claims involving* ***different issues***" and that a group may contain only one legal question.[89] Accordingly, the second issue in each of the 9 CIRP groups must stand alone and the second issue, on its own, must meet the minimum $50,000 amount in controversy for each CIRP group.

[89] *See also* Board Rule 8(A) (Nov. 1, 2021) distinguishng between "Dual eligible Medicare Part A/Medicaid, which is often referred to as dual eligible Medicare Part A Exhausted and Noncovered Days (*see, e.g.*, CMS Ruling 1498-R at 7-8)"; ***and*** "SSI eligible days s (*see, e.g.*, *Hall Render Individual, Optional and CIRP DSH Dual/SSI Eligible Group Appeals – Medicare Fraction v. Wisconsin Physicians Servs.*, PRRB Dec. No. 2017-D12 (Mar. 28, 2017))."

Here, as described above, the Providers failed to include any impact calculation for the second issue in these group appeals – the challenge to the Secretary's policy to include no-pay/exhausted Part A days in the Medicare fraction. Since Board Rules required the final SoPs for these 9 CIRP groups to establish the Board's jurisdiction over each of participants and these SoPs failed to include any documentation of the amount in controversy for the second issue, the Board finds that the Providers have failed to establish the Board's jurisdiction over the groups and the underlying participants. Accordingly, the Board dismisses each of the 9 CIRP groups in their entirety and denies the EJR request since jurisdiction is prerequisite to consideration of an EJR request.

B. Even If the Board Were to Have Jurisdiction Over Case No. 18-1814GC, the Board Would Dismiss 2 Participants From That CIRP Group.[90]

Lee Memorial Hospital (Prov. No. 10-0012, FYE 09/30/2016); and
Cape Coral Hospital (Prov. No. 10-0244, FYE 09/30/2016),

In Case No. 18-1814GC, the record shows that the as-filed cost reports for Lee Memorial Hospital ("Lee") and Cape Coral Hospital ("Cape Coral") were each received on February 24, 2017 but does not confirm when the Medicare Contractor accepted those as-filed cost reports. (The Board requested this information and the updated SoPs fail to include this information.) To the extent the as-filed cost report was, in fact, accepted by the Medicare Contractor, then the Medicare Contractor had 12 months after its receipt in which to issue an NPR, *i.e.*, had until February 25, 2018 to issue an NPR.

However, on April 2, 2018, both Lee and Cape Coral filed amended cost reports with the Medicare Contractor (*i.e.*, the Medicare Contractor received them on April 2, 2018) and, on April 6, and 18, 2018, the Medicare Contractor accepted the amended cost reports of Lee and Cape Coral, respectively. Notwithstanding the Medicare Contractor's acceptance of those amended cost reports, both Lee and Cape Coral filed appeals with the Board on August 22, 2018, base on the Medicare Contractor's failure to issue an NPR based on the as-filed original cost report.

42 C.F.R. § 413.24(f) specifies that "[a]mended cost reports to *revise cost report information* that has been *previously submitted* by a provider may be permitted or required as determined by CMS."[91] Similarly, the Provider Reimbursement Manual, CMS Pub. No. 15-1 ("PRM 15-1"), § 2931.2(A) restates that purpose and gives the following guidance on when it is appropriate to file an amended cost report:

> *A provider may file* or an intermediary may require *an amended cost report to*:

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[90] In that event, the Board would convert the CIRP group to an individual appeal since there would be only one participant remaining, but only if there were $10,000 in controversy for that issue. As explained in Section IV(A), the Providers have failed to include in the final SoPs for the 9 CIRP groups an impact calculation for the issue for which EJR is requested and, as such, these groups are fatally flawed.

[91] (Emphasis is added.)

1. *correct material errors detected subsequent to the filing of the original cost report.*
2. comply with the health insurance policies or regulations, or
3. reflect the settlement of a contested liability . . . .[92]

When a provider files a cost report, the provider may obtain appeal rights if the Medicare Contractor fails to issue a Notice of Program Reimbursement ("NPR"), which is the final contractor determination within 12 months from the date the cost report is received by the Medicare Contractor.[93] However, as specifically referenced in both the statute and the regulations, if a provider files an amended (or supplementary) cost report, the Medicare Contractor would then have 12 months from receipt of the amended cost report to issue an NPR before the provider could obtain rights to file an appeal based on the lack of a timely final determination.[94] This extension of time is necessary since an amended cost report "revise[s] cost report information that has been previously submitted. . . ."[95] Those revisions could correct a material error in the originally filed cost report or make changes to allow the cost report to comply with policy and regulation. Indeed, those changes could impact or even negate one or more of the issues that the provider would have wish to appeal from the original as-filed cost report. Therefore, when an amended cost report is filed, a Medicare contractor will ***not*** issue an NPR in response to an originally-filed cost report because such an NPR would be based on the inaccurate and outdated information contained in the original cost report, and superseded by the amended cost report. Rather, the Medicare contractor will issue a final determination (in this case a Notice of Program Reimbursement) in response to the perfected or amended cost report.

Pursuant to 42 C.F.R. § 405.1835(c),[96] in order to appeal the failure of the Medicare contractor to timely issue a final determination based upon the perfected or amended cost report, the provider must have "no fault" for the Medicare contractor's delay in issuing a final determination. In Case No. 18-1814GC, Lee Memorial Hospital and Cape Coral Hospital filed an appeal on August 23, 2017 alleging they failed to receive a final determination within twelve months in response to cost reports filed on February 24, 2017. However, both of these Providers had already filed amended cost reports in March of 2018 and the Medicare Contractors had accepted them in April of 2018. This filing with and acceptance by the Medicare Contractors of these amended cost reports is an intervening event and restarted the 12-month period for which the Medicare Contractor was to issue a final determination. Moreover, the Providers were aware of and cause that intervening event. Finally, again, the Board notes that both Lee and Cape Coral failed to

[92] *Emphasis added.*
[93] 42 C.F.R. § 405.1835(c).
[94] *Id.,* 42 U.S.C. § 1395oo(a)(1)(C).
[95] 42 C.F.R. § 413.24(f).
[96] 2 C.F.R. § 405.1835(c) states, in pertinent part: "(c) *Right to hearing based on untimely contractor determination.* Notwithstanding the provisions of paragraph (a) of this section, a provider . . . has a right to a Board hearing, as a single provider appeal, for specific items for a cost reporting period if— (1) A final contractor determination for the provider's cost reporting period is not issued (**through no fault of the provider**) within 12 months after the date of receipt by the contractor of the provider's perfected cost report or amended cost report (as specified in § 413.24(f) of this chapter)." (Bold and underline emphasis added.)

include in the record evidence of the Medicare Contractor's acceptance of their original as-filed cost report that they allege was not timely processed. Accordingly, the Board finds that these two Providers prematurely appealed the amended cost reports and would dismiss them for lack of jurisdiction had the Board not dismissed Case No. 18-1814GC in its entirety.

*****

In summary, the Board dismisses all 9 CIRP groups in their entirety due to a lack of jurisdiction over the groups and the underlying participants and denies the EJR requests for them since jurisdiction is a prerequisite to consideration of an EJR request. Accordingly, the Board closes these cases and removes them from the Board's docket. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review.

<u>Board Members Participating</u>

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

FOR THE BOARD:

6/22/2022

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

cc: Geoff Pike, First Coast Service Options, Inc. (J-N)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***Clarification on Board Dismissal Issued December 31, 2020***
13-2350GC Providence Health 2008 DSH Dual Eligible Days Group
13-2351GC Providence Health 2009 DSH Dual Eligible Days Group

Dear Mr. Ravindran:

In connection with the Provider's March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") groups,[1] the Provider Reimbursement Review Board ("Board") issued a dismissal on December 31, 2020. As explained more fully below, the Board is clarifying that its dismissal applies to all of these cases and, based on that dismissal, the Board is denying EJR and closing these cases.

I. Effect of COVID -19 on Board Operations and Staying of the 30-day Period to Respond to EJR Requests:

By letter dated April 9, 2020, the Board sent you notice that the 30-day time period for issuing an EJR had been stayed for these CIRP groups consistent with Board Alert 19. As explained below, that stay remains in effect.

On March 13, 2020, following President Trump's declaration of a national emergency as a result of COVID-19, the Centers for Medicare & Medicaid Services required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties "Temporary COVID-19 Adjustments to PRRB Processes." On April 9, 2020, subsequent to the submission of the EJR request, the Board notified you of the relevance of Alert 19 to the EJR request. Specifically, the Board notified you that, "[a]s the Board does not have access to the hard copy Schedules of Providers filed in the above-referenced list of . . . cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, whether "a provider of services may obtain a hearing under' the PRRB statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); see also 42 C.F.R. § 405.1842(b)." Accordingly, the Board stayed the 30-day period for responding to the EJR request for the above-captioned appeals.

[1] The EJR also included Case Nos. 17-0844GC, 16-1992GC, 17-2232GC, 18-1113GC, 14-3271GC, 14-2924GC, 15-0932GC, 15-1677GC, 18-0680GC, and 17-0955GC. The Board responded to the request for EJR in those cases under separate cover.

Although the ***hard copy*** Schedules of Providers was delivered to the Centers for Medicare & Medicaid Services ("CMS") mailroom on February 25, 2020, the Board did not receive the EJR request for the above-referenced appeals in its office until March 13, 2020, on the date that the Board and its staff were required to begin telework. Consequently, the Board did not have access to its office to locate the Schedules of Providers submitted on February 25, 2020. The Board has attempted to process EJR requests expeditiously and has been governed by the standards set forth in 42 C.F.R. § 405.1801(d)(2) when calculating the 30-day time period for issuing an EJR by excluding all days where the Board is not able to conduct its business in the usual manner.

Further, as explained in 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."[2] As described below, you have failed to give the Board sufficient documentation to permit it determine jurisdiction over these groups and the underlying documentation. As such, the 30-period for review of EJR requests has not yet commenced.

II. Board Decision:

At the outset, the Board notes that the Schedule of Providers with supporting jurisdictional documentation ("SoP") is critical for determining the Board's jurisdiction over the group and each of the underlying participants in a group. In this regard, Board Rule 20 addresses the procedures for Schedules of Provider ("SoPs") and the associated supporting jurisdictional documentation in group appeals. Board Rule 20.1 (Aug. 2018) addresses the filing requirements for SoPs:

> **20.1 Filing Requirements**
>
> Within 60 days of the full formation of the group (*see* Rule 19), the group representative must prepare a schedule of providers (Model Form G at Appendix G) and supporting jurisdictional documentation that demonstrates that the Board has jurisdiction over the providers named in the group appeal (*see* Rule 21).[3]

The content of the SoP is specified in Board Rule 21 (Mar. 2018):

[2] (Emphasis added.) *See also* 42 C.F.R. § 405.1842(a)(4)(ii); 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)).

[3] (Underline emphasis is added.)

> **Rule 21 Group Schedule of Providers and Supporting Documentation – Content**
>
> The schedule of providers *must include all providers* in the group *and provide the associated documentation to support jurisdiction of the participating providers*. The schedule has two parts, a summary page with columns A-G and supporting documentation under the corresponding tabs A-G.[4]

The Commentary to Board Rule 20.1.3 (Mar. 2018) explains the purpose behind the SoP:

> The schedule of providers is designed to assemble various elements of documentation to demonstrate that the Board has jurisdiction over each provider to be included in the group. Because some groups include numerous, even hundreds, of providers, a uniform format is essential to manage the documentation.
>
> The Model Form G – Schedule of Providers (Appendix G) is included to assist in this process. To this end, it is the responsibility of the group representative to gather these data elements and supporting documentation for each provider to be included in the group, even when such documentation may be on file with the Board in another appeal (e.g., the underlying individual appeal, another group appeal). Failure to submit the requisite documentation for one of the providers may result in the dismissal of that provider from the group.
>
> Finally, in conducting an initial format review, it is unnecessary for the Medicare contractor to comment on whether jurisdictional problems exist for any given provider or to identify every potential default in documentation.

In addition, 42 C.F.R. § 405.1840 and Board Rule 4.4 (2013) make clear that the Board may review jurisdiction at any time before closure of a case.[5] Finally, the Board notes that the Secretary has affirmed the importance of the SoP in determining jurisdiction:

> *Comment*: One commenter stated that filing a Schedule of Providers with supporting documentation can be a costly endeavor. This commenter recommended that any rule change that affects group appeals be prospective, that is, any pending group appeals should be

[4] (Underline and italics emphasis added.)
[5] In this regard, the Board further notes that § 405.1840(a)(3) specifies that the Board "may ***revise*** a preliminary determination of jurisdiction at ***any*** subsequent *stage of the proceedings* in a Board appeal." (Emphasis is added.)

> excepted to avoid unnecessary administrative filings and potential jurisdictional challenges for otherwise properly pending cases.
>
> *Response*: **We believe that the filing of a consolidated Schedule of Providers with supporting documentation** (which is already required by the Board in its current instructions) **is necessary**; **otherwise, the intermediary, the Board, the Administrator, and the courts could be required to review piecemeal jurisdictional documentation**. We note further that the current process, which requires providers to submit the Schedule to the intermediary, which, in turn forwards the Schedule to the Board (with comments either challenging or agreeing to the existence of jurisdiction), appears to be working efficiently. Accordingly, we are adopting the proposal without change.[6]

A. Improper Inclusion of Previously Dismissed Providers on the SoPs

You improperly include the following providers on the SoP for Case Nos. 13-2350GC and 13-2351GC because the transfer requests were filed ***after*** the Board had already dismissed and closed the provider's individual appeal:

- Case No. 13-2350GC—Participant #1 (Providence LC of Mary San Pedro MC, Prov. No. 05-0078, FYE 12/31/2008)—The Board dismissed the Provider's individual appeal under Case No. 15-0957 on October 15, 2015 for failure of the Provider to timely file its preliminary position paper ("PPP"). On or about October 30, 2015, the Board received transfer requests after the case had already been dismissed. On March 3, 2016, the Board denied the Provider's reinstatement request.

- Case No. 13-2350GC—Participant #4 (Providence LC of Mary Torrance MC, Prov. No. 05-0353, FYE 12/31/2008)— The Board dismissed the Provider's individual appeal under Case No. 15-1191 on October 15, 2015 for failure of the Provider to timely file its preliminary position paper ("PPP"). On or about October 30, 2015, the Board received transfer requests after the case had already been dismissed. On March 3, 2016, the Board denied the Provider's reinstatement request.

- Case No. 13-2351GC—Participant #7 (Providence Holy Cross Med Ctr, Prov. No. 05-0278, FYE 12/31/2009)—The Board dismissed the Provider's individual appeal under Case No. 15-1444 on October 15, 2015 for failure of the Provider to timely file its PPP. On or about October 30, 2015, the Board received transfer requests after the case had already been dismissed. On March 3, 2016, the Board denied the Provider's reinstatement request.

Thus, in each situation, the Board dismissed the individual appeal for failure to file a PPP ***prior to*** filing the transfer request at issue. In each instance, the Provider requested, and the Board denied,

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[6] 73 Fed. Reg. 30190, 30212 (May 23, 2008) (emphasis added).

reinstatement of the individual appeal so that the transfers could be effectuated. The Board reminds QRS that it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings. Accordingly, the above 3 Providers are ***not*** *currently* part of these cases and, as such, the Board does *not* consider them part of this EJR request for these cases (notwithstanding QRS' *improper* attempt to include these Providers on the relevant SoP).

B. No Jurisdiction Over Swedish Medical Center Cherry Hill and Swedish Medical Center in Case Nos. 13-2350GC and 13-2351GC

On February 20, 2020, QRS filed the Schedule of Providers with supporting documentation ("SoPs") in both of these CIRP groups, and then certified on March 13, 2020 that each group was fully formed. Per Board Rule 20.1, the Group Representative must prepare the SoP to "demonstrate[] that the Board has jurisdiction over the providers named in the group appeal." Similarly, the Commentary to Board Rule 20.2 explains that the SoP "is designed to assemble the various elements of documentation to demonstrate that the Board has jurisdiction over each provider to be included in the group" and that "it is the responsibility of the group representative to gather these data elements and supporting documentation for each provider to be included in the group, even when such documentation may be on file with the Board in another appeal (*e.g.*, the underlying individual appeal, another group appeal)." Accordingly, "[f]ailure to submit the requisite documentation for one of the providers may result in the dismissal of that provider from the group."

On March 13, 2020, QRS filed a request for EJR in these cases.

On November 30, 2020, the Board issued a Request for Information ("RFI") with respect to two Providers in each of the above-referenced appeals:

- Swedish Medical Center Cherry Hill ("Cherry Hill") (Prov. No. 50-0025, FYE 12/31/2008 &12/31/2009); and
- Swedish Medical Center ("Swedish Medical") (Prov. No. 50-0027, FYE 12/31/2008 & 12/31/2009).

Specifically, the RFI stated the following:

> The Board has reviewed the Schedule of Providers and accompanying jurisdictional documentation in the current cases and needs additional information from you. The record reveals that, through correspondence *dated June 14, 2013*, Quality Reimbursement Services ("QRS") requested that the Board establish new group appeals for two of the participants in Case No. 08-2597GC, the QRS 2004-2007 Providence Medicare Part A Title XIX Eligible Patient Days Group. QRS' request arose because, unlike the remaining participants in Case No. 08-2597GC, these two participants were not subject to remand under CMS Ruling 1498-R. Specifically, QRS requested that the following providers be placed in separate CIRP group appeals for the dual eligible days issue as required by the regulation, 42 C.F.R. § 405.1837(b):

> 1. Swedish Medical Center Cherry Hill, Prov. No. 50-0025 ("Cherry Hill") for FYEs 12/31/2008 and 12/31/2009; and
>
> 2. Swedish Medical Center, Prov. No. 50-0027 ("Swedish Medical") for FYEs 12/31/2008 and 12/31/2009.
>
> This regulation requires the Board establish a group appeal for all commonly owned providers for a legal issue common to the providers that arises in cost report periods ending in a given calendar year.
>
> On June 21, 2013, the Board responded to QRS' June 14, 2013 letter. The Board's letter confirmed that the Board established the following two CIRP groups and made the group-to-group transfers from Case No. 08-2597GC as follows:
>
> 1. Case No. 13-2350GC, Providence Health 2008 Dual Eligible Days Group, for Cherry Hill (FYE 12/31/2008) and Swedish Medical (FYE 12/31/2008).
>
> 2. Case No. 13-2351GC, Providence Health 2009 Dual Eligible Days Group, for Cherry Hill (FYE 12/31/2009) and Swedish Medical (FYE 12/31/2009).
>
> When the Schedule of Providers and accompanying jurisdictional documents were filed, the Group Representative *failed to include the original hearing request (including a statement of the issue) submitted in Case No. 08-2597GC* under Tab G for Cherry Hill and Swedish Medical in either Case No. 13-2350GC or Case No. 13-2351GC. <u>The complete copy (including the statement of the group issue appealed in Case No. 08-2597GC) is a necessary part of establishing the full history of the case is required by Board Rules 21.3.1 and 21.8.2. Without this information, the Board cannot make its jurisdictional rulings in this case</u> . . . .
>
> Consequently, the Board requires that the Group Representative file the missing information identified above for Cherry Hill and Swedish Medical in both Cases No. 13-2350GC and 13-2351GC ***within 30 days of this letter's signature date*** so that the Board may complete its jurisdictional review based on the Schedule of Providers submission. Based on the Group Representative's October 29, 2020 letter inquiring about the status of these EJR requests, the Board has determined to exempt the above filing deadlines from the Board Alert 19 suspension of Board filing deadlines. Accordingly, failure of the Group Representative to file a response to the Board's deadline will result in the Board taking remedial action, including but not to limited to dismissal.[7]

[7] (Underline emphasis added and footnotes omitted.)

QRS failed to respond to the RFI by the filing deadline, December 30, 2020. As a result, at 3:29 pm on Thursday, December 31, 2020 (the day following the deadline), the Board exercised its discretion under 42 C.F.R. § 405.1868 to dismiss Cherry Hill and Swedish Medical for QRS' failure to timely respond to the Board's request because this information was critical for determining the Board's jurisdiction over those participants.

Roughly, 3½ hours later, at 6:56 pm on Thursday, December 31, 2020, QRS responded to the RFI and filed its response in OH CDMS. Significantly, QRS' response ***failed*** to acknowledge *both* the Board's earlier dismissal *and* the fact that its response was untimely. Rather, QRS' untimely response simply noted that "[t]he requested document(s) accompany this letter and are being submitted electronically via the OH_CDMS system." Moreover, *QRS'* ***failed*** *to provide the primary information that the Board requested*, namely a copy of the group issue statement included for Case No. 08-2597GC. Instead, QRS' response attached the following appeal requests ***without establishing their relevance*** *to the CIRP groups at issue*:

1. An individual appeal request for Cherry Hill FY 2008 dated April 3, 2013 appealing an NPR dated October 16, 2012 and listing 7 different issues of which some were DSH related and others not;

2. An individual appeal request for Swedish Medical FY 2008 dated April 3, 2013 appealing an NPR dated October 15, 2012 and listing 7 different issues of which some were DSH related and others not;

3. An individual appeal request for Cherry Hill FY 2009 dated April 3, 2013 appealing an NPR dated November 6, 2012 and listing 8 different issues of which some were DSH related and others not; and

4. An individual appeal request for Swedish Medical FY 2009 dated April 3, 2013 appealing an NPR dated October 31, 2012 and listing 7 different issues of which some were DSH related and others not.

The Board recognizes that each of the above appeal ***requests*** includes the same Issue 4 for "DSH – Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)" and states "Note: This issue ***is being*** transferred to [Case No.] 08-2597GC."[8] However, this information is ***not relevant*** to the CIPR groups at issue because:

1. QRS' ***failed*** to provide proof (or other documentation to establish) that any of these 4 appeal requests, to establish individual provider cases, was ***actually <u>filed</u>*** with the Board and that the Board thereby established cases based on the alleged appeals (and issues stated within those appeal requests).

2. If these individual appeal requests were, in fact, filed with the Board, and done so in a timely and proper manner, the Board would have assigned a case number to these individual

[8] (Emphasis added.)

appeal requests. However, QRS' has ***failed*** to identify any case numbers assigned to alleged filing of appeal requests.[9] To this end, following a review of its records, the Board also was unable to identify any such individual appeal requests being filed for these Providers for FYs 2008 and 2009 and did not identify any case numbers assigned to individual appeal request for Cherry Hill and Swedish Medical for FYs 2008 and 2009.

3. Finally, even if the Board had established an individual case for these 2 Providers for FYs 2008 and 2009, the Providers would have had to have filed transfer requests to transfer from the individual appeal to the relevant CIRP group at issue. However, QRS' ***failed*** to furnish copies of any transfer requests filed with the Board (including proof of delivery/filing) to transfer the Providers from these alleged 4 individual appeals to Case No. 08-2597GC before being bifurcated therefrom to form Case Nos. 13-2350GC and 13-2351GC.[10]

The failure of QRS to provide the additional information renders QRS' untimely December 31st submission meaningless. Without this additional documentation and information, the Board cannot establish that Issue #4 in these 4 alleged appeal requests was, in fact, timely and properly pursued as part of individual appeals ***and*** then properly transferred to Case No. 08-2597GC from which it was bifurcated.[11]

QRS' failure to provide the above documentation suggests it does not exist and the record supports this finding. First, the record (as documented in the SoP summary charts for Case Nos.

[9] If a participant joins a group via transfer (as opposed to being a direct add), Board Rules 21.7 and 21.8 require the SoP to include a ***complete*** transfer history for that participant including all case numbers and supporting documentation.

[10] The fact that the *alleged* individual appeal states an intention to request a transfer (at some unspecified future date) of the issue to Case No. 08-2597GC would not qualify as a transfer request under Board Rules. Board 16.1(A) (Mar. 2013) specifies that a transfer request must be ***separate*** from an appeal request (*i.e.*, be made from an already established individual appeal) and include certain specific information and documents. Specifically, Board Rule 16.1(A) (Mar. 2013) states:

> **16.1 – Filing Requirements**
> **A. Transfers from an Individual Appeal to a Group Appeal**
> The Provider is required to attach the following supporting documents to its transfer request (Model Form D):
> 1. a copy of the relevant NPR or Revised NPR;
> 2. documentation showing that the issue being transferred is *currently part of the individual appeal* from which it is to be transferred; and
>   - If the Provider asserts that the issue was included in the initial appeal request, it MUST attach a copy of the initial appeal request showing that the issue was in fact included in the initial appeal request.
>   - If the Provider asserts that the issue was added subsequent to filing the initial appeal request, it MUST attach a copy of the letter and/or a copy of the Model Form C (Request to Add Issue(s) to an Individual Appeal) showing that the issue was in fact added subsequent to filing the initial appeal request.
> 3. a copy of the documents that are identified in the NOTE at Rule 7.1A if the Provider is appealing from a Revised NPR.

(Underline and italics emphasis added.)

[11] If these individual appeals were in fact established, it is unclear how the Provider pursued or dispensed with Issue 4 (*e.g.*, transferring it to other group appeals (creating an impermissible duplicate), withdrawing it, or abandoning it).

13-2350GC and 13-2351GC and the attachments to those SoP summary charts[12]) reflects that the 4 participants were ***directly added*** to Case No. 08-2597GC. Specifically, the final SoPs filed by QRS include the "Model Form E" ***direct add*** requests that were included behind Tab B for each of these Providers. Second, while QRS did not include any proof of delivery of those Model Form E's, it did provide (behind Tab G for each of these Providers) a copy of the Board's letter dated June 21, 2013 which, in part, acknowledged the Board's receipt of those Model Form E direct add requests. Specifically, as shown in the following excerpt, the Board's June 21, 2013 letter established Case Nos. 13-2350GC and 13-2351GC by bifurcating Case No. 08-2597GC (entitled "QRS 2000-2006 Providence Medicare Part A Title XIX Eligible Patient Days Group"):

> Finally, the letter from QRS identifies cost years ending after 12/31/2007 for two Providers which were not addressed by the Board's May 13, 2013 letter. Although these DIRECT APPEAL REQUESTS were received by the Board's office's on April 5, 2013, they were not associated with the case file at the time because the group appeal was in the process of being restructured. QRS has requested that these FYEs be established under a new CIRP group number for which QRS will be the designated representative.
>
> The Board Rules effective March 1, 2013, indicate that "Providers in a group appeal must have final determinations for their cost reporting periods that end within the same calendar year." Consequently, the Board is establishing separate group appeals for each FYE as indicated:
>
> | Group Name | PRRB Case No. |
> |---|---|
> | Providence Health 2008 DSH Dual Eligible Days | 13-2350GC |
> | Providence Health 2009 DSH Dual Eligible Days | 13-2351GC [13] |

As explained in Board Rule 16, a direct add is when a provider requests "to join an existing group by . . . directly appealing from a final determination" and, accordingly, as noted on Model Form E used for the direct adds at issue, "[t]he provider ***will adopt*** the issue title and issue statement of the group case."[14] In other words, when a provider is directly added to a group, its appeal rights can be no greater than those of the group which it joined.[15]

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[12] The Representative includes the Board's June 21, 2013 letter behind Tab G to document the bifurcation of these Providers from Case No. 08-2597GC to newly-established CIRP groups under Case Nos. 13-2350GC and 13-2351GC.

[13] (Caps emphasis in original.)

[14] (Emphasis added.)

[15] In support of this conclusion, the Board notes that 42 C.F.R. § 405.1837(f) includes the following limitations on group appeals:

- Per Paragraph 2, "[t]he Board may ***not*** consider, in one group appeal, more than one question of fact, interpretation of law, regulations, or CMS Rulings that is ***common to <u>each</u>*** provider in the appeal. (Emphasis added.)
- Per Paragraph 1, "[a]fter the date of receipt by the Board of a group appeal hearing request . . ., a provider may ***not*** add other questions of fact or law to the appeal, ***regardless*** *of whether the question is* ***common*** *to other members of the appeal . . . .*" (Emphasis added.)

In this regard, QRS failed to comply with the Board's request that it provide a copy of the group issue statement for Case No. 08-2597GC which, again, is the case from which Case Nos. 13-2350GC and 13-2351GC were bifurcated. Without the issue statement from Case No. 08-2597GC to confirm what the issues are for Case Nos. 13-2350GC and 13-2351GC, the Board cannot determine the validity of the issue statements for the derivative appeals.

QRS failed to timely respond to the Board's RFI. Thus, the Board's original dismissal was proper pursuant to its authority under 42 C.F.R. § 405.1868. Notwithstanding, the Board reviewed QRS' late filing and, as explained above, it failed to include the specific document requested by the Board, Because QRS failed to establish how the documentation included with the late filing traces to Case Nos. 13-2350GC and 13-2351GC, the Board finds it fatally flawed. Accordingly, the Board reaffirms its original December 31, 2020 dismissal pursuant to its authority under 42 C.F.R. §§ 405.1868(a)-(b).[16]

C. The Board dismisses Case Nos. 13-2350GC and 13-2351GC in their entirety (including the remaining participants therein) for lack of jurisdiction.

As set forth below, the Board dismisses Case Nos. 13-2350GC and 13-2351GC in their entirety based upon two independent legal bases. First, the dismissal of Cherry Hill and Swedish Medical serves as a basis to dismiss Case Nos. 13-2350GC and 13-2351GC in their entirety[17] because, without a proper group issue statement, a group cannot be established and the Board cannot determine its jurisdiction over the group. The Board's authority for the dismissal is based on 42 C.F.R. § 405.1840 as well as 42 C.F.R. §§ 405.1868(a)-(b). A second, and independent, basis for dismissal of Case Nos. 13-2350GC and 13-2351GC lies with the failure of the QRS to demonstrate that the Providers meet the $50,000 amount in controversy requirement *for the issue covered by each group.*

As explained above, QRS' failure to respond the Board's RFI means that the Providers have failed to establish the group issue statement and the whether the EJR request falls within the group appeal. The Board's review of the record in Case Nos. 13-2350GC and 13-2351GC confirms that the original appeal (Case No. 08-2597 entitled "QRS 2000-2006 Providence Medicare Part A Title XIX Eligible Patient Days Group") was also bifurcated into the following appeals:

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[16] An independent and alternative basis for dismissal of Cherry Hill and Swedish Medical from both Case No. 13-2350GC and 13-2351GC is the fact that QRS was ***not*** the authorized representative when it filed the direct add request. As shown in the SoPs for these cases, the representation letter is a one-page letter dated June 24, 2013 which is more than 2 ½ months after the direct add requests had been filed. Moreover, the letter does not specifically authorize representation of either Cherry Hill or Swedish Medical. Rather, it refers generically to the "Health Care System" for Providence Health & Services and "various" provider numbers for FYs 2008 through 2010 ***and*** *does **not** reference any attachment or enclosure*. Per Board Rule 6.4 (Mar.2013), "An authorized representative of the Provider must sign the appeal. If the authorized representative is not a Provider employee, attach an Authorization of Representation letter with the Initial Filing on the Provider's letterhead, signed by an owner or officer of the Provider."

[17] These bases would also apply equally to Cherry Hill and Swedish Medical to the extent the Board had not already dismissed them in Section II(B).

- Case No. 09-0748GC, entitled "Providence Health System 2000-09-30/2004 Dual Eligible Days Group"

- Case No. 09-0937GC, entitled "Providence Health & Services 10/1/2004-2007 Dual Eligible Days Group"

The Board remanded Case No. 09-0748GC to the Medicare Contractor pursuant to CMS Ruling 1498-R, based on the fact that the "appeals . . . challeng[ed] the exclusion from the DPP [*i.e.*, disproportionate patient percentage[18]] of non-covered inpatient hospital days for patients entitled to Medicare Part A, including appeals of days for which the patient's Part A hospital benefits were exhausted."[19]

On the other hand, the Board held a hearing for Case No. 09-0937GC and issued PRRB Dec. No. 2018-D43 wherein the class of days at issue were dual eligible days that had been excluded from ***both*** the Medicare fraction ***and*** the Medicaid fraction due to the alleged fact that the days at issue "were not billed to Medicare so [CMS] was unaware of the days and, therefore, the days were not in the SSI fractions calculated by CMS."[20] Accordingly, the only logical conclusion is that, since Case Nos. 13-2350GC and 13-2351GC were bifurcated from Case No. 08-2597GC, both Case Nos. 13-2350GC and 13-2351GC were limited to the appeal of the class of dual eligible days *excluded from* ***both*** the Medicare ***<u>and</u>*** Medicaid fractions.

Notwithstanding the Board's understanding that the issues in Case Nos. 13-2350GC and 13-2351GC concern the class of dual eligible days excluded from ***both*** the Medicare ***an***d Medicaid fractions, the EJR request does not address that issue (or class of days) but rather addresses two ***other***, separate issues (and separate classes of days):

1. "This appeal involves ***a challenge to the regulation*** *that mandates the inclusion of noncovered patient days in the Medicare fraction*, i.e., patient days not actually paid by the Medicare program. This includes exhausted benefit days, as well as Medicare secondary benefit days, in which payment for the specific patient days at issue are not actually paid by the Medicare program. . . . The provider contends that non-covered patient days should be included in the denominator of the Medicaid Fraction, and that where a patient is eligible for Medicaid, non-covered days belonging to that patient should be included in the numerator of the Medicaid Fraction. As noted below the Board has previously recognized that it does not have authority to require that *noncovered days be* ***excluded*** *from the Medicare fraction* ***<u>and</u>*** ***included*** *in the Medicaid fraction* and accordingly has granted EJR on this issue."

2. "Alternatively, the provider also contends that ***even if the challenged regulation were valid (which it is not)***, such that it would not be contrary to law to include non-covered days in the Medicare fraction, *it is impermissibly inconsistent to included unpaid* (i.e.,

[18] The DPP is the sum of the Medicare fraction *and* the Medicaid fraction and providers subject to the 1498-R remand for this issue were challenging the exclusion of dual eligible days not covered under Medicare Part A from ***both*** the Medicare fraction ***and*** Medicaid fractions.
[19] CMS Ruling 1498-R at 7 (April 28, 2010).
[20] PRRB Dec. 2018-D43 at 2 (July 5, 2018) (footnote omitted).

> non-covered days that are not paid by Medicare) *in the denominator of the Medicare fraction while **excluding** eligible but unpaid SSI days from the numerator of the Medicare Fraction*. This contention is a separate and independent basis for granting EJR in this case. As noted below the Board has previously recognized that it does not have authority to require that eligible but unpaid SSI days be included in the numerator of the Medicare Fraction."

The Board finds that neither of these 2 newly-created issues is part of either Case No. 13-2350GC or Case No. 13-2351GC and that QRS is improperly trying to add these 2 additional issues to these CIRP groups, in violation of 42 C.F.R. § 405.1837(f)(1).[21] First, the Group Representative has failed to provide the information requested by the Board to establish the group issue statement for the instant CIRP groups and whether that, original group issue statement encompassed these 2 additional issues. The need for this information is critical because, pursuant to 42 C.F.R. § 405.1837(a), there may be only one legal issue in a group appeal.[22] Notwithstanding the Group Representative's failure to provide the requested information, the procedural history of these 2 CIRP groups (as discussed above) demonstrates that ***neither*** of the above issues can be found within the original issue statement. Therefore, these newly-created issues are ***not*** part of either CIRP group and, through the act of submitting an EJR request on issues outside of the original issue statement, QRS has otherwise abandoned the Providers' original issue statement.[23]

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[21] These issues are different in that each one challenges different DSH policies and each issue seeks different changes to the DSH calculation and each involves different classes of days. *See* 42 C.F.R. §§ 405.1835(b), 405.1837(c) (requiring individual and group appeals to include explanations of how and why payment must be determined differently). *See also* 73 Fed. Reg. at 30212 (In response to a comment that the Board should have the authority to handle more than one question of fact or law in a group appeal give that "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 disproportionate share hospital (DSH) adjustment, which is determined by a combination of calculations, each of which may have more than one element in dispute", the Secretary stated that: "The statute requires that a group appeal involve only a common question (singular) of fact or interpretation of law or regulations. The regulations at § 405.1837(a)(2) further 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. What constitutes an appropriate group appeal issue in a given case will be determined by the Board.").

[22] To this end, § 405.1837(f)(1) confirms that no issues may be added to a group once it is established by filing a group appeal request. Further, § 405.1837(f)(2) provides the following instructions, in the event a group is founded with more than one issue:

> (2) The Board may ***not*** *consider*, in one group appeal, more *than* ***one question*** of fact, interpretation of law, regulations, or CMS Rulings that is ***common to <u>each</u>*** *provider in the appeal*. If the Board finds jurisdiction over a group appeal hearing request under § 405.1840 of this subpart -
> (i) The Board must determine whether the appeal involves specific matters at issue that raise more than one factual or legal question ***common to <u>each</u>*** *provider*; and
> (ii) When the appeal is found to involve more than one factual or legal question common to each provider, the Board must assign a separate case number *to the appeal of* ***<u>each</u> common*** factual or legal question and conduct further proceedings in the various appeals separately for each case.

(Emphasis added.)

[23] This is analogous to Board Rules governing position papers which specify that "If the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn." Board Rule 25.3 (Nov. 2021). Further Board Rule 41.2 specifies:

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

A second, independent bases for finding that the above 2 issues are not part of the instant CIRP groups is supported by the AiCs submitted with the final SoPs for the remaining participating providers. Pursuant to 42 C.F.R. § 405.1837(a)(3), the AiC for a group is determined in accordance with § 405.1839, which states, in pertinent 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 <u>different</u> issues**.
>
> (A) **A group appeal must involve a <u>single</u> 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).[24]

In addition, § 405.1837(e)(2) makes clear that the Board may consider dismissing a group appeal hearing request for failure to meet that requirement once the group is *fully formed*. Accordingly, a group's ***single*** issue must meet the minimum $50,000 amount in controversy threshold. A group of providers cannot aggregate claims across group issues for purposes of meeting the minimum $50,000 AiC threshold (such as by improperly including multiple issues within a group appeal request). As set forth below, the Board further finds that the Providers failed to meet the AiC requirement.

The amount in controversy ("AiC") calculations claimed in Case No. 13-2351GC support this conclusion. Specifically, for each of the 10 participants in Case No. 13-2351GC, the SoP includes, in Tab E, an AiC calculation that simply adds certain "No Pay Part A days" to the numerator of the Medicaid fraction. For Participant ##1-9, the AiC calculation adds 100 "No Pay Part A days" to the numerator of the Medicaid fraction, while for Participant #10, the AiC calculation adds 200 such days to the numerator of the Medicaid fraction. Significantly, none of these AiC calculations make any adjustment to the SSI fraction (whether the removal or addition of days). Accordingly, the AiC calculations included for Case No 13-2351GC appear to be similar to the scenario in the related Case No. 09-0937GC (noted above) wherein the class of days at issue were dual eligible days that had been excluded from ***both*** the Medicare fraction ***and*** the Medicaid fraction due to the alleged fact that the days at issue "were not billed to Medicare so [CMS] was unaware of the days and, therefore, the days were not in the SSI fractions calculated by CMS."[25]

- Upon failure of the provider or group to comply with Board procedures or filing deadlines (*see* 42 C.F.R. § 405.1868); . . . .

[24] (Emphasis added.)
[25] PRRB Dec. No. 2018-D43.

Similarly, the AiCs for the 2 founding participants (Participant ##6 and 7 for Cherry Hill and Swedish Medical respectively) submitted for Case No. 13-2350GC are calculated the same way (adding 100 "No Pay Part A days") and support a similar finding. Moreover, Participant ##2, 8 and 9 have AiCs calculated the same way (adding 100 "No Pay Part A days"). Therefore, the Board concludes that the Providers failed to meet the AiC requirement for a group case.

1. *The Board lacks jurisdiction over challenge to the FY 2005 IPPS Final Rule policy including no-pay/exhausted Part A days in the Medicare fraction*

QRS failed to establish in the Providers' EJR request, or SoPs, that the Board has jurisdiction over a challenge to the FY 2005 IPPS Final Rule because: (a) there is no evidence it ***ever*** part of either CIRP group (Case Nos. 13-2350GC or 13-2351GC), when they were established; and (b) issues may not be added to a group once it is established.[26] Although, the Board recognizes that 42 C.F.R. § 405.1837(f)(2)(ii) instructs the Board to bifurcate a group appeal in certain instances, that instruction is not applicable in this circumstance. The challenge to the FY 2005 IPPS Final Rule was ***never*** part of the group in the first instance, and not all providers in the group had transferred that issue to the group, thus that challenge was ***not*** common to each provider in the group.[27]

Further evidence of the *absence* of a challenge to the FY 2005 IPPS Final Rule is provided by the fact that ***none*** of the participants in Case No. 13-2351GC included in the SoP an AiC calculation for the challenge to the FY 2005 IPPS Final Rule. Similarly, 5 of the 7 remaining participants in Case No. 13-2351GC failed to include in the SoP an AiC calculation for the challenge to the FY 2005 IPPS Final Rule. Two participants in Case No. 13-2351GC (Participant #3, St. Joseph Medical Center; and Participant #5, Tarzana Medical Center) did include an AiC calculation for the FY 2005 IPPS Final Rule, thus apparently including an AIC for the challenge to the FY 2005 IPPS Final Rule.[28] However, bifurcation of these 2 participants,

[26] For purposes of this discussion the Board is referring to the challenge to the FY2005 IPPS Final Rule as one issue. The Board notes that, if this challenge were found to be properly part of this group, the Board would review it to determine if the challenge included multiple issues. In this regard, the Board takes administrative notice that it has generally required bifurcation when the challenge asserts that no-pay/exhausted Part A days should be excluded from the Medicare fraction and that such days should be included in the numerator of the Medicaid fraction when the underlying patient was also Medicaid eligible.

[27] The text of this regulation is included at *supra* note 22. *See also* 73 Fed. Reg. at 30210 (stating "We believe it is reasonable to expect that the parent corporation of commonly owned or controlled providers has a mechanism in place to identify issues that are common to more than one provider and to coordinate any appeals of these issues. Further, we believe that the parent corporation is in a better position than the Board to identify commonly-owned providers. Therefore, we are requiring a commonly owned provider to bring a timely appeal, as—(1) A group appeal (either initiating it or joining it) for an issue that is shared by other provider(s) to which it is related by common ownership; or (2) a single provider appeal for an issue that is peculiar to itself. (By ''timely'' we mean an appeal that satisfies the time limits stated in § 405.1835(a)(3) and § 405.1835(c)."); 73 Fed. Reg. at 30211 (stating "We agree with the commenter's concern. Accordingly, § 405.1837(e)(5) provides that, ***apart from the situation where the requirements for a group appeal are not met*** (that is, where there has been a failure to meet the amount in controversy requirement or the common issue requirement), *a provider may **not** transfer an issue from a group appeal to a single provider appeal*. In the situation where a provider has elected to form or join a group appeal, and the requirements for a group appeal ultimately are not met, the Board will transfer the provider's appeal to an individual appeal." (emphasis added))

[28] The other remaining participants in Case No. 13-2350GC are Participant ##3 and 5 and they had materially different AiCs. Specifically, the AiCs included for Participant ##3 and 5 included behind their respective Tab E in

pursuant to § 405.1837(f)(2)(ii), is ***not*** applicable since the challenge to the FY 2005 IPPS Final Rule was never part of the group appeal (much less common to ***each*** provider in the group[29]). The Board considered voiding the transfer for these 2 participants to send them back to their respective originating individual appeals. However, that discretionary option is only available to the extent the issue had not been pursued by that provider elsewhere (whether as part of the individual appeal or another group) ***and*** the individual appeal was either open/pending and/or could be reopened/reinstated. Here, there is no evidence that the issue was not pursued elsewhere by these two participants, and the 3-year period for reopening/reinstating the underlying individual appeal for these two participants[30] has lapsed.[31] Even if the Board had the authority to reinstate/reopen, the Board would not do so if the provider was at fault.[32]

Accordingly, based on the above, the Board finds that the challenge to the FY 2005 IPPS Final Rule (as stated in the Providers' EJR request) was never part of this group. As such, the Board denies the EJR request since jurisdiction is a prerequisite to Board consideration of an EJR request.

2. *The Board lacks jurisdiction over the Providers contention that "even if the challenged regulation were valid (which it is not) . . . , it is impermissibly inconsistent to include unpaid . . . in the denominator of the Medicare fraction while excluding eligible but unpaid SSI days from the numerator of the Medicare Fraction.*"

Finally, as previously noted, no issue may be added to a group appeal and the Providers have failed to establish that this issue was part of the group appeal when it was established. In this regard, the Board notes that QRS acknowledged in the Providers' EJR request that this issue was a "separate and independent basis for granting EJR in this case." As such, QRS recognized it was a separate issue but failed to request bifurcation. Moreover, even if the Providers had been able to establish that the group appeal request included this issue, the record is clear that QRS failed to demonstrate that these groups met the amount in controversy for this issue. Accordingly, the Board finds that it lacks jurisdiction over this issue and, since jurisdiction is prerequisite to Board consideration of an EJR request, the Board denies the Providers' EJR request for this issue.

The Board further notes that the EJR request is fatally flawed relative to this second newly-created issue because it does not meet the content requirements required for an EJR request ***on this second newly-created issue*** as set forth in Board Rule 42.3 (Aug. 2018) which specifies that

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the SoP were different and showed the exclusion of certain "DED Part A Days" from the Medicare fraction (resulting in an increase of 0.00388 and 0.0041 respectively) ***and*** the inclusion of certain "Dual Eligible Days – Part A" to the numerator of the Medicaid fraction (635 days and 3 days respectively). Thus, the AiCs for Participant ##3 and 5 are not in line with the Board's understanding of the issue in Case Nos. 13-2350GC. Rather, it appears to be in line with the primary issue laid out in the EJR request that was improperly added to these CIRP groups.

[29] No other provider in the group calculated an amount in controversy for the challenge to the FY 2005 IPPS Final Rule and, as such, it is clear that there can be no argument that this issue was, in fact, common to each provider in the group.

[30] The Board records reflect that the individual appeals for St. Joseph Medical Center under Case No 14-1055 and Tarzana Medical Center under Case No 14-2538 were each withdrawn on or about October 29, 2014.

[31] *See* 42 C.F.R. § 405.1885; Board Rule 47.1.

[32] Board Rule 47.1 states that "[t]he Board will not reinstate a[] . . . case if the provider was at fault."

an EJR request must have "a ***fully developed*** narrative that: • identifies the issue for which EJR is requested, • demonstrates that there are no factual issues in dispute, • demonstrates that the Board has jurisdiction, • identifies the controlling law, regulation, or CMS ruling, and • explains why the Board does not have authority to decide the legal question."[33] Each issue for which EJR is being requested must separately meet these content requirements and this is particularly relevant to a group which may only contain a ***single*** question of fact or law for purposes of Board jurisdiction over that group.

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In summary, the Board affirms its original dismissal of Cherry Hill and Swedish Medical from Case Nos. 13-2350GC and 13-2351GC and dismisses Case Nos. 13-2350GC and 13-2351GC pursuant to 42 C.F.R. § 405.1868(a)-(b) based on the Group Representative's failure to timely respond to the Board's request for information and to provide the essential information requested. There are several independent bases to dismiss these appeals that demonstrate the Board lacks jurisdiction over the groups, including, but not limited to, improperly adding to these CIRP groups the issues for which EJR is requested. Therefore, the Board denies the EJR request because it lacks jurisdiction over the appeals which is a prerequisite to Board consideration of an EJR request. Thus, the Board closes these 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:

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

FOR THE BOARD:

6/30/2022

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

Enclosures: Schedules of Providers

cc: John Bloom, Noridian Healthcare Services
Wilson Leong, FSS

[33] (Emphasis added)