DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Robert Roth, Esq.
Hooper, Lundy & Bookman, P.C.
401 9th Street, N.W., Ste. 550
Washington, DC 20004

RE: ***Denies Renewed EJR Requests and Closes Case No. 16-1125G; and Reinstates Case Nos. 14-0596 & 14-4263 and Issues Scheduling Order***
16-1125G HLB 2008 DSH Medicare Exhausted/MSP Days Medicaid & Medicare/SSI Fractns. Grp
14-0596 University of Chicago Hospitals
14-4263 Hackensack University Medical Center

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' Response to the Board's May 15, 2022 EJR Decision (filed on June 15, 2022), and the two *Renewed* Requests for Expedited Judicial Review ("EJR") in Individual Appeal (filed concurrently on June 15, 2022) which were both filed in Case No. 16-1125G. The decision of the Board to *close* Case No. 16-1125G, to *deny* the *Renewed* Requests for EJR in Individual Appeal (addressing Case Nos. 14-0596 and 14-4263), to *reinstate* Case Nos. 14-0596 and 14-4263, and to issue a Scheduling Order for additional information and briefing from the parties in Case Nos. 14-0596 and 14-4263 is set forth below.

Background

On May 14, 2022, the Board issued an EJR Decision which notified the parties that the Board did ***not*** have jurisdiction over Case No. 16-1125G for failure to meet the common issue requirement and that the EJR Request for the group appeal was denied since jurisdiction is a prerequisite. The Board advised the parties it was considering closing this case, and re-opening the Providers' underlying individual appeals so that their respective disparate Part A Exhausted Days issues could be pursued in the original, individual appeals. The Board proposed reinstating Case No. 14-4263 for Hackensack University Medical Center and Case No. 14-0596 for University of Chicago Hospitals. The Board stated that Case No. 13-2292 pertaining to St. Francis Medical Center was not eligible for reinstatement, but could be assigned a new case number. For reference, the Board has enclosed, as Attachment A, a copy of its May 14, 2022 letter.

On June 3, 2022, the Medicare Contractor responded to the Board's May 14, 2022 EJR Decision. The Medicare Contractor stated that it agreed with the Board's finding that Case No. 16-1125G was not jurisdictionally proper. The Medicare Contractor also agreed with the Board's proposal

to send the three Providers in the optional group under Case No. 16-1125G back to individual appeals to pursue their issue(s).

On June 15, 2022, the Providers' Representative responded to the Board's May 14, 2022 EJR Decision. While the Providers did not agree with the Board's jurisdictional finding and related EJR denial in Case No. 16-1125G, the Providers agreed that re-opening individual Case No. 14-4263 for Hackensack University Medical Center, and Case No. 14-0596 for University of Chicago Hospitals was appropriate in order for these two Providers to pursue their issues. The Providers' Representative stated that St. Francis Hospital no longer wished to pursue the Part A Exhausted and Non-Covered Days issue and, thus, was withdrawing its appeal. Additionally, on June 15, 2022, Hackensack University Medical Center and the University of Chicago each filed, ***in Case No. 16-1125G***, separate *Renewed* Requests for EJR relative to their respective individual appeals that had yet to be reinstated.

Closure of Case No. 16-1125G

As stated in the Board's May 14, 2022 EJR Decision, the Board does not have jurisdiction over optional group Case No. 16-1125G. Therefore, this group appeal is now closed.

Denial of EJR Requests filed in Case No. 16-1125G

Pursuant to Board Rule 2.1.1, effective November 1, 2021, all filings must be submitted ***electronically*** using the Office of Hearings Case and Document Management System ("OH CDMS") unless an exemption is granted by the Board.

On June 15, 2022, both Hackensack University Medical Center and the University of Chicago each *electronically* filed, ***in Case No. 16-1125G***, separate *Renewed* Requests for EJR relative to their respective individual appeals that had yet to be reinstated. The Board will ***not*** consider these filings because they were ***not*** properly filed since they were not filed in the correct case and, accordingly, the Board obligations under 42 C.F.R. § 405.1842 have not yet been triggered. Moreover, these filings are further defective in that they fail to address the Board's May 14, 2022 jurisdictional rulings regarding the scope and nature of the Dual Eligible Days issue(s) that Hackensack University Medical Center and the University of Chicago each appealed and how the Board has jurisdiction over the EJR request based on these jurisdictional findings.[1] Due to these fatal flaws, the Board denies these EJR requests. As OH CDMS is the official system of record for these each of these individual appeals, the Providers must *electronically* re-file the Renewed Request for EJR for both Hackensack University Medical Center and University of Chicago Hospitals ***in their respective individual appeals*** – Case No. Case No. 14-4263 for Hackensack

[1] For example, the Board found that the University of Chicago only appealed the omission of certain dual eligible days from the Medicaid fraction as confirmed by both the issue statement and the amount in controversy calculation. *See* Attachment A.

University Medical Center and Case No. 14-0596 for University of Chicago Hospitals.[2] This filing can only be done after these individual appeals have been reinstated. Once the Renewed Requests for EJR have been ***properly*** filed *electronically* in the individual appeals, then the Board will conduct the prerequisite jurisdictional review and the review of the EJR request.

Reinstatement of Case Nos. 14-0596 and 14-4263

The Board is reinstating Case No. 14-4263 so that Hackensack University Medical Center may pursue Issues 1c and 5 (which are listed, in OH CDMS, as Issues 3 and 9 respectively). The Board is also reinstating Case No. 14-0596 for University of Chicago Hospitals so it may pursue Issue 7 entitled "DSH Medicare/Medicaid Dual Eligible Patient Days."[3] Both Case No. 14-0596 and 14-4263 are open as of the date of this letter.

No individual appeal will be opened for St. Francis Hospital which has confirmed that it will no longer be pursuing the DSH Dual Eligible Days issues which originated in Case No. 13-2292, and were then requested to be transferred to Case No. 16-1125G. Accordingly, the Board considers St. Francis' appeal of this issue effectively withdraw and no further Board action will be taken.

Forthcoming EJR Requests in Case Nos. 14-4263 and 14-0596

In anticipation of the Providers filing EJR requests in the proper individual appeals, Case Nos. 14-4263 and 14-0596, which will challenge the treatment of certain patient days in the Medicare and Medicaid fractions used to calculate their Disproportionate Share Hospital ("DSH") payments, the Board is requiring the parties to supplement their filings related to the EJR Requests following the Supreme Court's recent decision in *Becerra v. Empire Health Found.*, No. 20-1312 (S. Ct. June 24, 2022).

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulation 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 particular 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 Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if:

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[2] The Board notes there are circumstances in which submissions related to multiple cases only need to be filed once in OH-CDMS, however, a request for expedited judicial review is not one of these circumstances. *See* PRRB Rule 3.6.1.

[3] The Board found that this issue only pertains to the "'*omission* of certain patient days attributable to patients who were eligible for both Medicare and Medicaid' and the amount in controversy calculation appended to the issue statement only adjusted the Medicaid fraction and showed ***no*** adjustment to the Medicare fraction as it remained the same at 0.10071 both before *and* after the amount in controversy calculation." *See* Attachment A at 24-25 (emphasis in original which quotes Case No. 14-0596, Appeal Request, Issue 7 (Nov. 7, 2013) (emphasis added)).

- It is dissatisfied with the final determination of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determination. A Provider 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; [4] and

- The amount in controversy for the matter at issue is $10,000 or more.[5]

On Friday, June 24, 2022, the Supreme Court issued a decision in *Becerra v. Empire Health Foundation* ("*Empire*"),[6] resolving the disagreement between various Federal Circuit Courts as to whether the relevant policy change, adopted in FY 2005 rule change, was permissible.[7] The Supreme Court "approve[d] HHS's understanding of the Medicare fraction"[8] and found that "[t]ext, context, and structure all support calculating HHS's way",[9] namely:

> In that fraction [*i.e.*, Medicare fraction], individuals "entitled to [Medicare Part A] benefits" are all those qualifying for the program, regardless of whether they are receiving Medicare payments for part or all of a hospital stay. That reading gives the "entitled" phrase the same meaning it has throughout the Medicare statute. And it best implements the statute's bifurcated framework by capturing low-income individuals in each of two distinct populations a hospital serves.[10]

The EJR Requests (and any responses thereto) previously submitted pertaining to Hackensack University Medical Center and University of Chicago Hospitals were submitted prior to the Supreme Court's recent ruling in *Empire* and, therefore, do not discuss the Supreme Court's resolution of the regulatory dispute at issue. Accordingly, in light of the *Empire* development and the recent improper refiling of the EJR requests, the Board hereby exercises its authority under 42 C.F.R. § 405.1842(e)(3) to require that the Providers address the following in Case Nos. 14-0596 and 14-4263 ***within twenty-one (21) days of this letter's signature date***:

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[4] 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).
[5] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[6] No. 20-1312, 2022 WL 2276810 (S. Ct. 2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).
[7] *See Stringfellow Mem'l Hosp. v. Azar*, 317 F. Supp. 3d 168, 190, 194 (D.D.C. 2018) (finding the rule procedurally sound); *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 920 (2013) (finding the Secretary's interpretation to be reasonable and permissible); *Empire Health Found. v. Price*, 334 F. Supp. 3d 1134, 1163 (E.D. Wash. 2018) (finding the regulation procedurally invalid), *aff'd* 958 F.3d 873 (9th Cir. 2020), *rev'd* No. 20-1312 (S. Ct. June 24, 2022).
[8] *Empire*, at *1.
[9] *Id*. at *11.
[10] *Id*.

1. Provide a case-status update on each of these cases, Case Nos. 14-0596 and 14-4263, and confirm whether the Provider in each of these individual appeals remain committed to pursuing the reinstated issue(s) and intend to refile an EJR request.

2. For each case/issue not being pursued, request withdrawal.

If the Providers electronically file, in their respective individual appeals, a renewed EJR request, then the Board requires that the Providers address the following in that EJR request:

- Pursuant to Board Rule 42.3, an EJR request must demonstrate that the Board has jurisdiction. This discussion in the EJR request must address the Board's May 14, 2022 jurisdictional findings regarding the nature and scope of the relevant issue(s) appealed (*see* Attachment A).

- The EJR request must address the relevance of the Supreme Court's decision in *Empire* on any challenge raised in the EJR request.[11]

The Board's request for information is designed to determine whether the Board's jurisdictional review, and review of the case in general, has otherwise been rendered moot by Supreme Court's *Empire* decision. If a Provider files a response confirming that it will continue to pursue EJR in either Case No. 14-0596 or Case No. 14-4263, then FFS must file its response to the Provider's filing (if any), ***within twenty-one (21) days of the filing date of the Provider's response***.

In conclusion, the optional group under Case No. 16-1125G is now closed and the Renewed Requests for EJR in Individual Appeals ***as electronically filed in Case No. 16-1125G*** are fatally flawed and denied. The Board has taken the following actions:

1. Reinstated the individual appeal under Case No. 14-0596 for University of Chicago Hospitals for Issue 7 entitled "DSH Medicare/Medicaid Dual Eligible Patient Days";[12]

2. Reinstated the individual appeal under Case No. 14-4263 for Hackensack University Medical Center for Issues 1c and 5 (which are listed, in OH CDMS, as Issues 3 and 9 respectively); and

3. Requested that, *within 21 days of this letter's signature date*, the Providers file a status update in these cases as a result of the Supreme Court's recent decision in *Empire*.

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[11] This information is necessary for the Board to rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii).

[12] The Board found that this issue only pertains to the "'*omission* of certain patient days attributable to patients who were eligible for both Medicare and Medicaid' and the amount in controversy calculation appended to the issue statement only adjusted the Medicaid fraction and showed ***no*** adjustment to the Medicare fraction as it remained the same at 0.10071 both before *and* after the amount in controversy calculation." *See* Attachment A at 24-25 (emphasis in original which quotes Case No. 14-0596, Appeal Request, Issue 7 (Nov. 7, 2013) (emphasis added)).

If the Providers should re-file Requests for EJR pertaining to DSH Dual Eligible Days in their respective individual appeals (which are now open), then they must address the impact of the Board's May 14, 2022 decision and the Supreme Court's decision in *Empire* on their EJR request.

In issuing this Scheduling Order, the Board is mindful of the Covid-19 pandemic. *Notwithstanding, be advised that the above filing deadlines in this Scheduling Order are **firm** and, in light of the time sensitive nature of the EJR requests that were filed but denied, the Board is **exempting** these deadlines from the Board Alert 19 suspension of Board-set filing deadlines*. Accordingly, given the import of the *Empire* decision, failure of the Group Representative to comply with the Scheduling Order and timely file its response (without a Board-approved extension) may result in dismissal of the relevant newly-reinstated individual appeals.

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:

7/1/2022

X Clayton J. Nix

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

Enclosure Attachment A—Board Determination Dated May 14, 2022 (27 pages)

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

ATTACHMENT A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Robert Roth, Esq.
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RE: ***Expedited Judicial Review Decision***
HLB 2008 DSH Medicare Exhausted/MSP Days Medicaid & Medicare/SSI Fractions Grp
Case No. 16-1125G

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 15, 2022 request for expedited judicial review ("EJR") in the above-referenced *optional* group appeal. The decision of the Board to ***deny*** the EJR is set forth below.

I. Background

This *optional* group was filed on February 29, 2016. The *optional* group appeal request was established with 2 participants, the ***minimum*** number of providers needed to establish an *optional* group. Specifically, the following two Providers were transferred from individual appeals to the optional group to establish it:

- Hackensack University Medical Center (Prov. No. 31-0001) which requested transfer from Case No. 14-4263,[1] and
- Francis Hospital (Prov. No. 42-0032) which requested transfer from Case No. 13-2292.[2]

On March 26, 2019, University of Chicago Hospitals (Prov. No. 14-0088) requested transfer from Case No. 14-0596 to this optional group appeal.[3] On May 22, 2019, the Board granted the transfer of ***two*** DSH Part A Exhausted/MSP Days issues (in both DSH fractions) from Case No. 14-0596 into the optional group under Case No. 16-1125G.

[1] Case No. 14-4263, *Request to Transfer Issue to a Group Appeal* at 1 (Feb. 26, 2016).
[2] Case No. 13-3392, *Request to Transfer Issue to a Group Appeal* at 1 (Feb. 26, 2016).
[3] Case No. 14-0596, *Request to Transfer Issue to a Group Appeal* at 1 (Mar. 26, 2019).

II. Issue Statement in Optional Group Appeal

In issue statement included with the group appeal request for Case 16-1125G, the Providers frame the DSH Medicare Exhausted/MSP Days Medicaid and Medicare SSI Fractions issue as follows:

> **Statement of the Group Issue**
>
> Whether the Hospital's FY 2008 Medicare DSH payments were improperly low because of the failure to properly account for inpatient days for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare Part A exhausted days, Medicare managed care days, Medicare Secondary Payer days, Medicare medical denials, and Medicare technical denials. This issue relates both to the Medicare/SSI fraction and the Medicaid fraction.
>
> In accordance with 42 U.S.C. § 1395ww(d)(5)(F)(vi)(II), days relating to hospital inpatients who, at the time of service, were "eligible for medical assistance under a State plan approved under title XIX," but "not entitled to benefits under [Medicare] Part A" are to be included in the numerator of the Medicaid fraction. Dually-eligible Part A exhausted days, Medicare medical denials. MSP days, Medicare technical denials, medically-unnecessary days, and other similar days *should 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 when the services were provided. Non-dually-eligible Part A exhausted days, Medicare medical denials, MSP days, Medicare technical denials, medically-unnecessary days, and other similar days also *should be excluded from the Medicare/SSI fraction.*
>
> CMS is required to recalculate the Hospitals' FY 2008 DSH payments to assure that (a) all dually-eligible Part A exhausted days, Medicare medical denials, MSP days, Medicare technical denials, medically-unnecessary days, and other similar days are included in the numerator of the Medicaid fraction and excluded from the Medicare/SSI fraction and (b) all non-dually-eligible Part A exhausted days, Medicare medical denials, MSP days, Medicare technical denials, medically-unnecessary days, and other similar days are excluded from the Medicare/SSI fraction. When making the revisions required by this appeal, the MAC must also make all

> corresponding necessary cost report corrections, including to the Hospitals' capital DSH payment.[4]

In the Providers' Request for EJR they frame the issues as:

> The Group Appeal challenges the substantive and procedural validity of the rule that the Centers for Medicare & Medicaid Services ("CMS") adopted in the federal fiscal year ("FFY") 2005 Inpatient Prospective Payment System ("IPPS") Final Rule for determining the inpatient days for which a patient is "entitled to" Medicare Part A benefits for purposes of calculating Medicare disproportionate share hospital ("DSH") payments. Specifically, the Hospitals contend that their DSH payments at issue were not made in accordance with law because CMS's FFY 2005 rule does not properly account for determining inpatient days attributable to patients where there was no Medicare coverage or where Medicare did not make a Part A payment, including but not limited to Part A exhausted days, Medicare medical denials, Medicare technical denials, medically-unnecessary days, custodial care days, and MSP days ("Part A exhausted and non- covered days") in the statutory DSH payment formula. *The Hospitals contend that CMS's rule improperly requires treating Part A exhausted and non-covered days as days for which the patient was "entitled to" Medicare Part A.*[5]

The footnote appended to the above quote notes that "[t]his issue impacts the calculation of both Medicare DSH fractions—the 'Medicare/SSI' fraction and the 'Medicaid' fraction." The following excerpt sheds additional light on the nature of the EJR request.

> In the FFY 2005 IPPS Final Rule, CMS then finalized the opposite rule from what it had proposed and reversed its decades-old policy: For discharges on or after October 1, 2004, CMS's rule requires counting Part A exhausted and non-covered days in the Medicare/SSI fraction and excluding such days for dually-eligible patients from the Medicaid fraction numerator. 69 Fed. Reg. 48,916, 49,098-99 (August 11, 2004). This new rule has had the effect of decreasing hospitals' DSH payments from FFY 2005 forward. Days for patients who were not "entitled to" Part A payments for the days at issue—because, for example, they had exhausted their Part A benefits or had another insurer primary to Medicare—have been

[4] Case No. 16-1125G, *Model Form B – Group Appeal Request*, Tab 2 "Statement of the Group Issue" (Feb. 26, 2016) (emphasis added).
[5] Request for Expedited Judicial Review at 1-2 (Apr. 15, 2022)("EJR Request") (footnote omitted).

> *categorically excluded from the Medicaid fraction's numerator (for the dually-eligible) and only included in the Medicare/SSI fraction*.[6]

III. Issue Statements in Individual Appeals

A. Issue Description in Case No. 14-4263 – Participant 1, Hackensack University Medical Center

On September 9, 2014, Hackensack University Medical Center ("Hackensack") filed an individual appeal to establish Case No. 14-4263. Hackensack University described the Medicare Part A Exhausted Days in the DSH Medicaid Fraction as Issue No. 1c (Issue No. 3 in OH-CDMS) in Case No. 14-4263 as follows:

> Days unlawfully not counted in the Medicaid fraction relating to HUMC's patients who were eligible for both Medicare and medical assistance, but for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare Part A exhausted days, Medicare managed care days, Medicare Secondary Payor days, Medicare medical denials, and Medicare technical denials. *See* Audit Adjustments 150, 151, 821 and 822. The amount in controversy for this issue is approximately $226,776. *See* Attachment E.[7]

Hackensack described the DSH Medicare Part A Exhausted Days in the Medicare/SSI Fraction issue as Issue No. 5 (Issue No. 9 in OH-CDMS) in Case No. 14-4263 as follows:

> DSH Medicare Exhausted Days/MSP Days – Medicare/SSI Fraction: Whether HUMC's FY 2008 Medicare DSH payment was improperly low because of the failure to properly account for inpatient days for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare Part A exhausted days, Medicare managed care days, Medicare Secondary Payor days, Medicare medical denials, and Medicare technical denials. *See* Audit Adjustment 821-824. The amount in controversy for this issue is approximately $226,776. *See* Attachment J.[8]

On February 29, 2016, the Group Representative filed a request to establish the instant optional group and concurrently requested the transfer of Hackensack to the instant optional group describing the issue being transferred as:

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[6] *Id.* at 3 (emphasis added).
[7] Case No. 14-4263, *Appeal of Notice of Program Reimbursement* at 4, Issue No. 1c (Sept. 8, 2014).
[8] Case No. 14-4263, *Appeal of Notice of Program Reimbursement* at 4, Issue No. 5 (Sept. 8, 2014).

> Whether the Hospitals' FY 2008 Medicare DSH payments were improperly low because of the failure to properly account for inpatient days for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare exhausted days, Medicare managed care days, Medicare Secondary Payer days, Medicare medical denials, and Medicare technical denials. This issue relates to both the Medicare/SSI fraction and the Medicaid fraction.

Hackensack was one of two founding participants for the instant optional group (the other was St. Frances Hospital, as discussed below).

B. Issue Description in Case No. 13-2292 – Participant 2, St. Francis Hospital

On May 31, 2013, St. Francis Hospital ("St. Francis") filed an individual appeal to establish Case No. 13-2292. St. Francis described Medicare DSH Adjustment Medicare Fraction – SSI Percentage as Issue 3 in Case No. 13-2292 as follows:

> **Whether the SSI factor** component used to calculate the Hospital's FY 2008 Medicare DSH payment, and capital PPS payment, **was <u>improperly low</u> because it was not calculated properly**. *See* Audit adjustments 23, 25, 28, 28, 42 (inpatient rehabilitation unit), 42, and 50 (capital). The amount in controversy for this issue is not known with certainty at this time but is expected to well-exceed $10,000.[9]

Further, St. Francis described DSH Medicare Exhausted Days in the DSH Medicaid Fraction as Issue 4.d in Case No. 13-2292 as follows:

> d. Days *unlawfully **not** counted in the Medicaid fraction* relating to the Hospital's patients from the following categories, including those who were eligible for both Medicare and Medicaid: …(c) Medicare Part A exhausted days, (d) Medicare Secondary Payor days, (e) Medicare medical denials, and (f) Medicare technical denials.
>
> *See* Audit Adjustment 7. The amount in controversy for this issue [i.e. Issue 1.a to 1.d] is not known with certainty at this time but is expected to well-exceed $10,000.[10]

[9] (Bold and underline emphasis added.)
[10] Case No. 13-2292, *Appeal of Notice of Program Reimb.* at 4, Issue No. 4d (May 31, 2013) (emphasis added).

On February 29, 2016, the Group Representative filed a request to establish the instant optional group and concurrently requested the transfer of St. Frances to the instant optional group describing the issue being transferred as:

> Whether the Hospitals' FY 2008 Medicare DSH payments were improperly low because of the failure to properly account for inpatient days for which there was no Medicare coverage or for which Medicare did not make a Part A payment, including but not limited to Medicare exhausted days, Medicare managed care days, Medicare Secondary Payer days, Medicare medical denials, and Medicare technical denials. This issue relates to both the Medicare/SSI fraction and the Medicaid fraction.

The transfer request still listed the amount in controversy as unknown but expected to exceed $10,000.[11] St. Francis was one of two founding participants for the instant optional group (the other was Hackensack, as discussed above).

C. Issue Description in Case No. 14-0596 – University of Chicago Hospitals

On November 8, 2013, the University of Chicago Hospitals filed an individual appeal to establish Case No. 14-0596. The University of Chicago Hospitals described Issue 7 entitled "DSH Medicare/Medicaid Dual Eligible Patient Days" in Case No. 14-0596 as follows:

> Brief description of the issue:
>
> Whether the MAC and CMS properly determined the Provider's operating and capital DSH payments, due to the ***omission*** *of certain patient days attributable to patients who were eligible for both Medicare and Medicaid*.
>
> Audit adjustment number(s): 4, 38, 43 and 69
> Estimated Amount in Controversy: $463,151. *See* attached calculation.
>
> Statement identifying the legal basis for the appeal:
>
> The Disproportionate Share Adjustment is calculated according to a formula that includes the determination of a hospital's

[11] The Board recognizes that the Schedule of Providers for Case No. 16-1125G includes an *undated* amount in controversy calculation behind Tab 2-E. As neither the appeal request *nor* the transfer request included a calculation of an amount in controversy, the Board must conclude that this amount in controversy calculation document was created contemporaneous to the filing of the final Schedule of Providers on April 15, 2022. This amount in controversy calculation is entitled "Amount in Controversy – Exclusion of Medicaid Eligible – Dual Eligible Days" showing a net amount in controversy of $65,559.00.

> "disproportionate share percentage" 42 U.S.C. § 1395ww(d)(5)(F)(vi). This percentage is defined as the sum of the Medicaid fraction, and the Medicare fraction. The Provider contends that the Medicaid fraction has not been calculated in accordance with Medicare regulations and Manual provisions as described in 42 C.F.R. § 412.106. Further, the Provider contends that the Medicare/Medicaid dual-eligible patient days have *not been properly included* in the DSH calculation. ***Specifically***, *the Medicaid fraction should include* any inpatient day where the patient is both Medicaid eligible and Medicare is the secondary payer (MSP) or those inpatient days where the patient is Medicaid eligible and his Medicare benefits are exhausted (exhausted days).[12]

Consistent with this issue statement, the estimated amount in controversy documentation attached to Issue 7 showed: (1) ***no*** change in the SSI fraction as it remained 0.10071 both before and after the estimated amount in controversy calculation for Issue 7; and (2) a change of 1200 day in the "Total Medicaid Days" due to "***Uncounted*** Dual Eligible Days"[13] resulting in a change in the Medicaid fraction. This document also included a footer stating: "For purposes of this estimated impact calculation, the Provider has assumed that ***uncounted*** Dual Eligible Days amount to a minimum of 2% of Total Medicaid Days."[14]

On January 28, 219, the University of Chicago Hospitals requested that the Board reopen the fully formed optional group under Case No. 16-1125G to permit it to transfer from Case No. 14-0596 into that optional group. In response to that request, on March 12, 2019, the Board issued a letter in Case No. 14-0596 to the Hospital which stated:

> The Provider Reimbursement Review Board ("PRRB") is in receipt of your request dated January 28, 2019 to transfer two DSH issues into a single optional DSH Group appeal that has been deemed complete. The Board has reviewed your request to transfer the two issues to a complete group and finds that the issue description ***in group appeal 16-1125G*** covers both the Medicare and Medicaid fractions as they relate to the 2008 DSH Medicare Exhausted/MSP Days issue. In addition, the Board finds that the transfers of the issues into the complete group will facilitate the resolution of the individual appeal. Therefore the request to transfer the two issues from 14-0596 to 16-1125G is granted…[15]

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[12] Case No. 14-0596, *Appeal Request*, Issue No. 7 (Nov. 7, 2013) (italics and bold emphasis added).
[13] (Emphasis added.)
[14] (Emphasis added.)
[15] (Emphasis added.)

The Board notes that the above reopening to permit the transfer does *not* include any findings of jurisdiction over the issues purportedly being transferred but rather only states that "the issue description ***in group appeal under Case No. 16-1125G*** covers both the Medicare and Medicaid fractions as they relate to the 2008 DSH Medicare Exhausted/MSP Days issue."[16] Accordingly, on March 27, 2019, following the Board's reopening of the optional group, the Provider filed its "Request to Transfer ***Two*** DSH Issues To Group Appeal 16-1125G" and, in support thereof, *only* included, as Enclosure C, a copy of Issue 7 from the individual appeal as the issue being transferred. On May 22, 2019, the Board granted the transfer of the DSH Dual Eligible days issues from Case No. 14-0596 to the optional group under Case No. 16-1125G.

IV. 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").[17] Under IPPS, Medicare pays predetermined, standardized amounts per discharge, subject to certain payment adjustments.[18]

The statutory provisions governing IPPS contain a number of provisions that adjust reimbursement based on hospital-specific factors.[19] 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.[20]

A hospital may qualify for a DSH adjustment based on its disproportionate patient percentage ("DPP").[21] 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.[22] The DPP is defined as the sum of two fractions expressed as percentages.[23] 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*

[16] (Emphasis added.)
[17] *See* 42 U.S.C. § 1395ww(d)(l)-(5); 42 C.F.R. Part 412.
[18] *Id.*
[19] *See* 42 U.S.C. § 1395ww(d)(5).
[20] *See* 42 U.S.C. § 1395ww(d)(5)(F)(i)(I); 42 C.F.R. § 412.106.
[21] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(i)(I), (d)(5)(F)(v); 42 C.F.R. § 412.l06(c)(l).
[22] *See* 42 U.S.C. §§ 1395ww(d)(5)(F)(iv), (vii)-(xiii); 42 C.F.R. § 412.106(d).
[23] *See* 42 U.S.C. § 1395ww(d)(5)(F)(vi).

> *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 . . . .[24]

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.[25]

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.[26]

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.[27]

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.[28] 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.[29]

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[24] (Emphasis added.)
[25] 42 C.F.R. § 412.106(b)(2)-(3).
[26] (Emphasis added.)
[27] 42 C.F.R. § 412.106(b)(4).
[28] 68 Fed. Reg. 27154, 27207 (May 19, 2003).
[29] *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."[30] The Secretary maintained that this was consistent with the inclusion of Medicaid patient days even after the patient's Medicaid coverage is exhausted.[31] 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."[32]

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).[33] Notwithstanding, the Secretary recognized that there were other plausible interpretations and acknowledged, on a practical level, it was often difficult for Medicare contractors[34] 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.[35]

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.[36] 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. [37] 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.[38]

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[30] *Id.*
[31] *Id.*
[32] *Id.* at 27207-27208.
[33] *Id.* at 27207-08.
[34] Medicare administrative contractors ("MACs") were formerly known as fiscal intermediaries or intermediaries.
[35] 68 Fed. Reg. at 27208.
[36] *Id.*
[37] *Id.*
[38] *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.[39] 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."[40]

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.[41] 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.[42]
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> ****
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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*

[39] 68 Fed. Reg. 45346, 45421 (Aug. 1, 2003).
[40] *Id.*
[41] 68 Fed. Reg. 28196, 28286 (May 18, 2004).
[42] 69 Fed. Reg.48916, 49098 (Aug. 11, 2004) (emphasis added).

> *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*.[43]

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."[44] 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."[45] 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 . . .[46]

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. . . .[47]

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[43] *Id.* at 49099 (emphasis added).
[44] *Id.*
[45] *See id.* at 49099, 49246.
[46] (Emphasis added.)
[47] (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."[48]

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.[49] 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.[50]

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*"),[51] 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.[52] 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.[53] Further, the Court found that the 2005 Final Rule was procedurally sound and the product of reasoned decision making.[54] The *Stringfellow* decision was appealed to the U.S. Court of Appeals for the D.C. Circuit ("D.C. Circuit");

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[48] *Id.*
[49] 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).
[50] (Citations omitted and emphasis added.)
[51] 317 F. Supp. 3d 168 (D.D.C. 2018).
[52] *Id.* at 172.
[53] *Id.* at 190.
[54] *Id.* at 194.

however, the D.C. Circuit later dismissed it.[55] 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*"),[56] 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*,[57] 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.[58]

In the third case, *Empire Health Found. v. Price* ("*Empire*"),[59] 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."[60] 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.[61] 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[62] and that the regulation is procedurally invalid.[63]

The U.S. Court of Appeals for the Ninth Circuit ("Ninth Circuit") reviewed the Washington District Court's decision in *Empire*[64] 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.[65] 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."[66] 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

[55] *See* 2019 WL 668282.
[56] 718 F.3d 914 (2013).
[57] 657 F.3d 1 (D.C. Cir. 2011).
[58] 718 F.3d at 920.
[59] 334 F. Supp. 3d 1134 (E.D. Wash. 2018)
[60] *Id.* at 1141.
[61] *Id.*
[62] *Id.* at 1162.
[63] *Id.* at 1163.
[64] 958 F.3d 873 (9th Cir. 2020), *reh'g en banc denied* (9th Cir. Oct. 20, 2020).
[65] *Id.* at 884.
[66] *Id.* at 884.

Legacy Emanuel Hospital and Health Center v. Shalala ("*Legacy Emanuel*")[67] 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."[68] 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."[69] 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."[70] 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.[71] 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.

V. Providers' Position

The Providers argue that CMS has been inconsistent with the treatment of days for Medicare inpatients who have exhausted their Part A benefits or whose days have otherwise not been paid (Part A exhausted and non-covered days). They note that, historically, these days were not counted in the Medicare fraction, but in the FY 2004 IPPS Proposed Rule, CMS proposed counting the days in the numerator of the Medicaid fraction for patients who were dually-eligible. The Providers also claim the FY 2004 IPPS Proposed Rule incorrectly stated CMS' policy was to include Part A exhausted and non-covered days in the Medicare/SSI fraction. The Providers note that CMS did not enact the 2004 rule proposal. However, the FY 2005 IPPS Final Rule finalized the opposite policy – that Part A exhausted and non-covered days would be counted in the Medicare fraction and excluded from the numerator of the Medicaid fraction. The Providers claim this is the opposite rule from what was proposed, and it also reversed a decades old policy. The Providers contend this new rule has had the effect of decreasing hospitals' DSH

[67] 97 F.3d 1261, 1265-66 (9th Cir. 1996).
[68] 958 F.3d at 885 (citing and quoting *Legacy Emanuel*).
[69] *Id.* at 886.
[70] *Id.*
[71] *Bacerra v. Empire Health Fdtn.*, No. 20-1312 (S. Ct. cert. granted July 2, 2021).

payments from FY 2005 forward because exhausted non-covered days are now categorically excluded from the Medicaid fraction's numerator and are only included in the Medicare/SSI fraction.[72]

The Providers claim that these days should be included in the numerator of the Medicaid fraction (for dually-eligible patients) and excluded from the Medicare fraction because these days relate to patients who were not "entitled to" Part A benefits "for such days" when the services were provided. They state that CMS' policy deserves no deference. CMS misstated both its current and proposed policies in its FY 2004 and 2005 rulemaking, failed to provide adequate notice and opportunity for comment, and has interpreted "entitled to benefits under [Medicare Part A]" for purposes of the DSH fractions in a manner inconsistent with the statute and precedent. They note that the decision in *Empire Health Foundation v. Azar* vacated the regulation at issue. Since the regulation was held to be invalid and is being reviewed by the Supreme Court, and because the Board lacks the authority to review the validity of a regulation, EJR is appropriate.[73]

VI. 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 Issue Statement for the Optional Group Contains 2 Issues

The Providers maintains in the optional group issue statement that no-pay Part A days should not be counted in the SSI fraction and that, instead, those days should be counted in the numerator of the Medicaid fraction to the extent they involve patients who were also Medicaid eligible. As noted in the EJR request and in the regulatory history cited above, the Secretary adopted its policy of including no-pay Part A days in the Medicare fraction policy in the FY 2005 IPPS Final Rule.

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.

[72] EJR Request at 3.
[73] *Id.* at 5.

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*").[74] 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 individual is either eligible for Medicare Part A, or not)."[75]

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).[76] 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' assertion 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*");[77] 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

[74] 746 F.3d 1102, 1108 (D.C. Cir. 2014).
[75] *Id*. (emphasis added).
[76] 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).
[77] 718 F.3d 914 (D.C. Cir. 2013). Significantly, this is unlike the situation involving Medicaid patients

> 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).[78]

Indeed, the relief requested by the Providers here was rejected by the Administrator in 2000 in *Edgewater Med. Center v. Blue Cross Blue Shield Ass'n* ("*Edgewater*").[79] Thus, in the event the Supreme Court upholds the 9th Circuit's decision in *Empire*, 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.[80]

Accordingly, the Board finds that the optional group issue statement requesting exclusion of no-pay Part A days from the SSI fraction *is a separate and distinct issue* from the group issue statement requesting inclusion of the subset of no-pay part A days involving patients who are eligible for Medicaid *into* the numerator of the Medicaid fraction.[81] If the Board were to find jurisdiction over the optional group *and* were to find "the appeal involves specific matters at issue that raise more than one factual or legal question *common to* ***each*** *provider*,"[82] then the Board would need to bifurcate the optional group "for each ***common*** factual or legal question"[83] as noted in 42 C.F.R. § 405.1837(f)(2). However, as described below, that situation is not present here.

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[78] CMS Ruling 1498-R2 at 3 (emphasis added). *See also* CMS Ruling 1498-R.
[79] *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*").
[80] *See* discussion at the end of Section IV.B.
[81] The Board recognizes the letter it issued on February 26, 2016 suggesting that the optional group contained a single issue. However, the letter did not include analysis and, upon further review, the Board finds it erred as explained above. In this regard, 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.
[82] (Emphasis added.)
[83] (Emphasis added.)

B. Jurisdiction over the Optional Group

In the instant case, Hackensack, St. Francis, and the University of Chicago Hospitals transferred into the optional group from individual appeals, but the Board has not yet conducted a jurisdictional review of each of these providers to confirm that their participation in the optional group is proper.[84] The regulation at 42 C.F.R. § 405.1840 (2013) addresses Board jurisdiction and states in pertinent part:

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

[84] With respect to the University of Chicago Hospitals, the Board notes that the fact that, on March 12, 2019, the Board granted the Provider's request to join a fully formed group is not a finding of jurisdiction. In this regard, Board Rule 19.5 simply states that the "Board has discretion to grant or deny a request to join a fully formed group." Similarly, the fact that the Board makes the following finding regarding the issue statement in the optional group is not a finding of jurisdiction regarding the University of Chicago Hospitals: "the issue description ***in group appeal 16-1125G*** covers both the Medicare and Medicaid fractions as they relate to the 2008 DSH Medicare Exhausted/MSP Days issue." Even it if could be so construed, 42 C.F.R. § 405.1840 (and, in particular § 1840(a)(3)) makes clear that such a finding would only be preliminary and could be changed by the Board.

> (b) *Criteria*. Except with respect to the amount in controversy requirement, the jurisdiction of the Board to grant a hearing must be determined separately for each specific matter at issue in each contractor or Secretary determination for each cost reporting period under appeal. **The Board has jurisdiction to grant a hearing over a specific matter at issue in an appeal only if the provider has a right to a Board hearing as a single provider appeal under § 405.1835 of this subpart or as part of a group appeal under § 405.1837[85] of this subpart, as applicable**. . . .
>
> (c) *Board's jurisdictional findings and jurisdictional dismissal decisions*. (1) **In issuing an EJR decision** under § 405.1842 of this subpart **or a hearing decision** under § 405.1871 of this subpart, as applicable, **the Board must make a separate determination of whether it has jurisdiction for each specific matter at issue** in each contractor or Secretary determination under appeal. A decision by the Board must include specific findings of fact and conclusions of law as to whether the Board has jurisdiction to grant a hearing on each matter at issue in the appeal.[86]

Similarly, Board Rule 4 address Board Jurisdiction/Appealing Issues and provides the following general requirements at Board Rule 4.1 (Mar. 2013):

> **4.4 Dismissal for Lack of Jurisdiction**
>
> Appeals that fail to meet the jurisdictional requirements will be dismissed. A jurisdictional challenge may be raised at any time during the appeal; however, for judicial economy, the Board strongly encourages filing any challenges as soon as possible. *The Board may review jurisdiction on its own motion at any time. The parties cannot waive jurisdictional requirements*.[87]

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[85] 42 C.F.R. § 405.1837(a) states in pertinent part:

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

[86] (Bold and underline emphasis added.)

[87] (Italics emphasis added.) This Rule is now located at Board Rule 4.1.

With regard to jurisdiction, the Board notes that Board Rule 20 addresses the procedures for Schedules of Provider ("SoPs") and the associated supporting jurisdictional documentation in group appeals. Board Rule 20.1 (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).[88]

The content of the SoP is specified in Board Rule 21 (Mar. 2018):

> **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.[89]

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.[90]

42 C.F.R. § 405.1837 specifies, in subsection (b)(2)(i), that there must be at least two providers to establish an optional group and, in subsection (c), that providers requesting to establish an optional group must demonstrate they meet the requirements in subsection (a) that they individually satisfied the requirements for a Board hearing under § 405.1835(a) and the matter at issue in the group appeal involves a single question of fact or interpretation of law *that is common to **each** provider in the group*. Board Rules 12.5(A), 13, and 14 (July 1, 2015) address these points. Board Rule 12.5 and 12.6 address how many providers are required to establish an optional group appeal, stating:

> **A. Optional Group Appeals**
>
> At least two different Providers are required to initially form an optional group. The Board may limit the number of Providers in an optional group appeal, or divide existing optional groups into various case numbers, as it deems necessary to ensure efficient

[88] (Underline emphasis added.)
[89] (Underline and italics emphasis added.)
[90] 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 added.)

> case management. The Board may request the parties' input prior to limiting or dividing a case.[91]

Board Rule 13 provides that group appeals must have one common issue, stating:

> **Rule 13 – Common Group Issue**
>
> The matter at issue must involve a *single* ***common*** question of fact or interpretation of law, regulation or CMS policy or ruling. A group case is not appropriate if facts that must be proved are unique to the respective Providers or if the undisputed controlling facts are not common to all group members. Likewise, a group appeal is inappropriate if the Board could make different findings for the various Providers in the group. However, for illustration purposes in a brief or hearing, facts relating to a specific Provider(s) may be presented as representative of all group members. Refer to Rules 7 and 8 for guidance.[92]

Board Rule 14 confirms that the Board may later dismiss the group appeal if it is found to be deficient:

> **Rule 14 – Acknowledgment of Group Appeal**
>
> The Group Representative and the Lead Intermediary selected by the Group Representative will receive an Acknowledgement via e-mail from the Board indicating that the group appeal has been received and the case number assigned. *If the Provider's appeal does not comply with the filing requirements, the Board may dismiss the appeal or take other remedial action.* An acknowledgement does not limit the Board's authority to request more information or dismiss the appeal if it is later found to be deficient.[93]

As explained below, the Board finds the two initial founding Providers in Case No. 16-1225G – Hackensack in Case No. 14-4263, and St. Francis in Case No. 13-2292 – did *not* appeal the same issue in their underlying individual appeals as that in the instant group case which is a requirement of an *optional* group appeal. As a result, the Board finds this *optional* group was not properly established with two providers sharing a common issue.

Consistent with the issue statement for the optional group (as discussed above), Hackensack appealed in its Appeal Request for Case No. 14-4263 two issues – both Part A Exhausted/MSP

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[91] Provider Reimbursement Review Board Rules (July 1, 2015).
[92] *Id.* (emphasis added).
[93] *Id.* (emphasis added).

Days in the DSH Medicaid Fraction and Part A Exhausted/MSP Days in the Medicare/SSI Fraction. These issues were numbered as Issues 1.c and 5, respectively.

In contrast, St. Francis appealed the alleged unlawful exclusion of Part A Exhausted/MSP Days from the DSH Medicaid Fraction as Issue 4.d in the Appeal Request for Case No. 13-2292 (and did not include any documentation of the amount in controversy as part of the appeal request[94]). St. Francis also generically alleged in Issue 3 in the Appeal Request for Case No. 13-2292 that the Medicare fraction was "improperly low because it was not calculated properly"; however, St. Francis did not describe in Issue 3 why it was "improperly low" or why "it was not calculated properly." In particular, with respect to Issue 3, it did *not* challenge the inclusion of no-pay Part A days in the Medicare fraction or request that those days be excluded from the Medicare fraction or otherwise refer to (or challenge) the FY 2005 IPPS Final Rule establishing the Secretary's policy of including no-pay Part A days in the Medicare fraction. This lack of specificity is contrary to the requirements at 42 C.F.R. § 405.1835(b) (2013), stating in pertinent part:

> (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, including a specific identification of the intermediary's or Secretary's determination under appeal.
>
> (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 <u>each</u> disputed item** (or, where applicable, why the provider is unable to determine whether Medicare payment is correct because it does not have access to underlying information concerning the calculation of its payment).

[94] See supra note 11 (discussing how the amount in controversy calculation included with the Schedule of Providers was not part of either St. Francis' individual appeal request or the transfer request to join the instant optional group).

> (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**.[95]

Accordingly, it is clear that Issue 3 is not a valid, appealable issue under the 42 C.F.R. § 405.1835(b) as it lacks sufficient specificity and, as such, cannot encompass the Medicare faction portion of Case No. 16-1125G. Indeed, as a point of contrast, the Board notes that with respect to Part C days under Issue 5, the Provider described in detail its issue with the Part C days as it relates to both the Medicare and Medicaid fraction:

> Whether the hospital's FY 2008 Medicare DSH payment was understated because (a) *the Medicare/SSI fraction improperly included* inpatient hospital days attributable to ***Medicare Part C enrollee patients*** and (b) *the Medicaid fraction improperly excluded* inpatient hospital days attributable to *dually-eligible* ***Medicare Part C*** *enrollee patients*.[96]

This further supports the Board finding that St. Francis' Appeal Request in Case No. 13-2292 failed to properly include an appeal of the Medicare Fraction as it relates to group issue statement seeking exclusion of no-pay Part A days from the Medicare fraction.

Based on the above findings, the Board finds that the issues appealed by the initial Providers in their individual appeals are different and that, as a result, these two Providers could not properly establish an optional group appeal on February 29, 2016 which is required to contain a single *common* issue for both Providers. In so ruling, it becomes clear that St. Francis may not now have the same fact and legal pattern as Hackensack's request for inclusion in the Medicaid fraction of no-pay Part A days relating to dual eligibles. As such, the Board concludes that the optional group was improperly formed with Hackensack and St. Francis.

The Board has also reviewed the issue appealed by the University of Chicago Hospitals which was described as DSH Medicare/Medicaid Dual Eligible Patient Days (Issue No. 7) in the Appeal Request for Case No. 14-0596. The Board finds this issue is also different than the group issue stated in Case No. 16-1125G, in that it only appealed the "*omission* of certain patient days

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[95] *See also* Board Rule 8 (Mar. 2013) (stating at 8.1 that "Some issues may have multiple components. To comply with the regulatory requirement to specifically identify the items in dispute, each contested component must be appealed as a separate issue and *described as narrowly as possible* using the applicable format outlined in Rule 7. See common examples below." (emphasis added)).

[96] At no point during this issue statement does the Provider make any requests for relief or any challenges that can be attributable to no-pay Part A days *in general* (*i.e.*, outside of the Part C context). In this regard, the Board notes that Part C days is a separate issue from no-pay Part A days and, in this regard, are discussed and handled separately in the FY 2005 IPPS Final Rule.

attributable to patients who were eligible for both Medicare and Medicaid"[97] and the amount in controversy calculation appended to the issue statement only adjusted the Medicaid fraction and showed ***no*** adjustment to the Medicare fraction as it remained the same at 0.10071 both before *and* after the amount in controversy calculation.

Even though the transfer request pertained to Issue 7 in the appeal request, the Board did review the individual appeal and finds further support there for its finding that the University of Chicago Hospitals did *not* appeal or challenge the Medicare fraction as it relates to the inclusion of no-pay Part A days in the Medicare fraction. Issue 6 relates to the "Medicare DSH SSI Percentage"; however, the Board finds that Issue 6 does not contain sufficient specificity in compliance with 42 C.F.R. § 405.1835(b) to encompass a challenge to the inclusion of no-pay Part A days to the Medicare fraction because it does not comply with that regulation to explain "[w]hy the provider believes Medicare payment is incorrect" and "[h]ow and why the provider believes Medicare payment must be determined differently." In this regard, the University of Chicago Hospitals described the issue in very generic terms of "[w]hether the MAC and CMS properly determined the Provider's SSI Percentage" and simply contends that the Medicare fraction "as generated by the SSA and put forther by CMS is understated." Indeed, as a point of contrast, the Board notes that with respect to "HMO Days" or Medicare C days under Issue 10, the Provider described in detail its issue with the Part C days as it relates to both the Medicare and Medicaid fraction:

> Whether the inpatient days attributable to Medicaid-eligible patients *enrolled in* ***Medicare Part C*** *plans* should be reflected in the Medicaid percentage, instead of the Medicare/SSI percentage, when determining the Provider's operating and capital DSH payments.[98]

This further supports the Board finding that the University of Chicago Hospitals in Case No. 14-0596 *failed* to include an appeal of the Medicare Fraction as it relates to group issue statement seeking exclusion of no-pay Part A days from the Medicare fraction.

The Board notes that, although it previously approved the reopening of Case N. 16-1126G to allow the University of Chicago Hospitals to transfer to this group appeal, that permission did *not* include any jurisdictional findings as it relates to the University of Chicago Hospitals and the Issue 7 that was transferred from the individual appeal into the instant optional group.[99] In this regard, consistent with 42 C.F.R. § 405.1840 and Board Rules 4.4 (Mar. 2013) and 20 and 21 (Aug. 2018), the Board reviews jurisdiction in a group for each of the participants following full formation of the group and the submission of the Schedule of Providers with supporting documentation. Accordingly, upon review of the jurisdictional documentation, the Board finds that the University of Chicago Hospitals is not properly part of this group as the issue statement

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[97] Case No. 14-0596, *Appeal Request*, Issue No. 7 (Nov. 7, 2013) (emphasis added.)
[98] At no point during this issue statement does the Provider make any requests for relief or any challenges that can be attributable to no-pay Part A days *in general* (*i.e.*, outside of the Part C context). In this regard, the Board notes that Part C days is a separate issue from no-pay Part A days and, in this regard, are discussed and handled separately in the FY 2005 IPPS Final Rule.
[99] *See supra* note 84.

in its underlying individual appeal that was transferred (*i.e.,* Issue 7 which is the ***only*** issue statement from the individual appeal request that was included with the transfer request as part of Enclosure C to document the issue being transferred) was different than this group appeal (as described in the group issue statement) because the issue actually transferred (*i.e*., Issue 7) only pertained to the "omission" of certain dual eligible days from Medicaid fraction as confirmed by the amount in controversy calculation for Issue 7 which only impacted the Medicaid fraction.

Based on the above findings and rulings, the Board is considering re-opening the underlying individual appeals (Case Nos. 14-4263 – Hackensack University Medical Center, Case No. 13-2292 – St. Francis Hospital and Case No. 14-0596 – University of Chicago Hospitals), for these three Providers so that their respective disparate Part A Exhausted Days issues may be pursued in the original individual appeals, to the extent its eligible for reinstatement,[100] or under a new individual case number. Prior to making these transfers, the Board requires comments regarding the proposed reopening of those individual appeals (or establishment of new individual appeals as relevant) and associated transfers from both the Group Representative and the Medicare Contractor regarding this case restructuring ***by Wednesday, June 15, 2022***.[101]

*Be advised that this filing deadline is **firm** and that, given the fact that this jurisdictional decision is being made in the context of an EJR request, the Board has determined to **exempt** this deadline from the Board Alert 19 suspension of Board-set deadlines*. Accordingly, failure of the Provider to timely file may result in remedial action (*e.g*., dismissal) pursuant to the Board's authority under 42 C.F.R. § 405.1868(b). Similarly, failure of the Medicare Contractor to timely reply may result in the Board issuing written notice to CMS describing the contractor's actions and requesting that CMS take appropriate action pursuant to 42 C.F.R. § 405.1868(c).

B. Board's Decision Regarding the EJR Request

The Board denies the Providers' request for EJR for the optional group under Case No. 16-1125G because, contrary to the representations made in Section IV of the EJR request, the Board does not have jurisdiction over *the optional group*, as explained above, and jurisdiction is a prerequisite for EJR as required by 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R.§ 405.1842(f)(1). The Board further notes that the 30-day period in which the Board has to rule on an EJR request does not begin until after the Board finds jurisdiction consistent with 42 C.F.R. § 405.1837(b)(2) which states: "Under paragraphs (d) and (e) of this section, a provider may request a determination of the Board's authority to decide a legal question [*i.e*., file a request for EJR], but *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." Here

[100] Case No. 14-4263 pertaining to Hackensack was closed on August 10, 2021 and, as such, is within the 3-year period allowed for reinstatement. Case No. 13-2292 pertaining to St. Frances closed on August 31, 2018 and, thus, is not eligible for reinstatement. Case No. 114-0596 pertaining to the University of Chicago Hospitals closed on August 1, 2109 and, as such is within the 3-year period for reinstatement.

[101] As the Board is issuing this letter on a Saturday, the Board has set this deadline 30 days following the first business day (*i.e*., 30 days following Monday, May, 16, 2022).

the Board did *not* find jurisdiction which necessarily results in the EJR denial. As such, the 30-day period never began and this is consistent with case law upholding the Secretary's policy and implementation of 42 U.S.C. § 1395oo(f)(1).[102]

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:

5/14/2022

X Clayton J. Nix

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

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

[102] *See Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* 1999 WL 717830 (N.D. Cal. 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* 1988 WL 71367 (E.D. Pa.); *Good Samaritan Hosp. v. Heckler,* 986 WL 8497 (D. Neb.); *Lester E. Cox Med. Ctrs. v. Sebelius*, 691 F. Supp. 2d 162 (D.D.C. 2010).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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

RE: ***EJR Denial and Dismissal***
QRS Empire Health 2005 SSI Dual Eligible Days CIRP Group
Case No. 17-0554GC

Dear Mr. Ravindran:

In connection with the Providers' March 13, 2020 request for expedited judicial review ("EJR") for the above-referenced common issue related party ("CIRP") group for Empire Health Foundation ("Empire Health"),[1] the Provider Reimbursement Review Board ("Board") issued the following requests for information ("RFIs") to the Group Representative, Quality Reimbursement Services ("QRS"), and QRS filed responses to those RFIs as reflected below:

- An RFI dated November 30, 2020: (a) requesting comments on its proposal to expand the instant CIRP group to encompass an additional year, 2008, to permit the transfer of the then-sole provider in Case No. 15-3123GC to the instant CIRP group; and (b) requiring QRS to revise the Schedule of Providers ("SoP") for the instant CIRP group to include certain missing information and then resubmit that SoP. On December 24, 2020 QRS filed its response objecting to the Board's proposed consolidation and, on December 30, 2020, filed additional documentation on in support of its position.

- An RFI dated January 21, 2021: (a) notifying the Group Representative "that, ***within fifteen (15) days of this letter's signature date***, [the Group Representative] must request a group-to-group transfer of Deaconess Medical Center (Prov. No. 50-0044, FYE 12/31/2005) from Case No. 17-1412G to 17-0554GC"[2] because Deaconess Medical Center ("Deaconess") was pursuing the same issue for the same fiscal year in multiple appeals in violation of 42 C.F.R. § 405.1837(b); and (b) notifying QRS that it had not provided sufficient information in objection to the proposed consolidation and requiring QRS to submit a revised SoP following the consolidation of Case No. 15-3123GC into Case No. 17-0554GC. On January 28, 2021, QRS responded by asserting that the Board's mandate to request a group-to-group transfer from Case No. 17-1412G to

[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.
[2] (Emphasis in original.)

17-0554GC was in error because a group must have a single common question and these cases each had a *different* common question – one involving the DSH Medicaid fraction and the other involving the DSH Medicare fraction. On February 22, 2021, QRS filed a revised SoP for Case No. 17-0554GC that reflected the Board's proposed consolidation but also filed in Case No. 15-3123GC its continued objection to the proposed consolidation with additional documentation in support.

Subsequently, on April 21, 2022, the Board dismissed Case No. 13-3123GC, thereby eliminating the Board's pending proposed action to expand the instant CIRP group. Set forth below is the Board's jurisdictional determination over the instant CIRP group, and underlying participants, as well as the Board's determination on the EJR request.

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 the Group Representative 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 ("CMS") required its personnel to telework and limited employees' access to their offices. On March 26, 2020, the Board issued Alert 19, notifying affected parties of the "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 be 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.

Although the ***hard copy*** Schedule of Providers was delivered to the Centers for Medicare & Medicaid Services mailroom on February 25, 2020, the Board did not receive the EJR request for the above-referenced appeal 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 original SoP, filed on March 3, 2020.[3]

[3] QRS filed a revised SoP on February 22, 2021 in response to a Board request and, as discussed *infra*, it has come to the Board's attention that QRS improperly included additional materials in the revised SoP that were outside of the Board's request and were included without leave of the Board and without notice to the Board or the opposing party (*e.g.*, including an errata sheet listing changes made).

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."[4]

As described below, the Group Representative has failed to give the Board sufficient documentation to permit it to find jurisdiction over these groups. As such, the 30-period for review of this EJR request still has not yet commenced.

II. Issue In Dispute in the Group

The complete issue statement in this group appeal reads as follows:

> **Group Issue: [DSH] Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)**
>
> **Statement of the Issue**
>
> Whether patient days associated with Medicare Part A and Title XIX eligible patients *should be excluded* from the SSI or Medicare fraction of the [DSH] calculation. Further, whether the MAC *should have excluded from the* SSI or *Medicare 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 payment*.

[4] (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)).

Statement of the Legal Basis

The Provider contends that the 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 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 the Medicare Part A payments*, in the Medicaid percentage of the Medicare DSH calculation. *Since CMS has stated that only "paid" days will be used in the SSI percentage*, the Provider contends 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 [*sic* be] *excluded from both the numerator and the denominator of the SSI percentage factor* in the Medicare DSH formula.

The ***sole*** founding participant in the group was Valley Hospital Medical Center (Prov. No. 50-0119, FYE 12/31/2005 ("Valley")) and Valley was directly added to the group based on a Model Form E direct add request. The amount in controversy ("AiC") listed for Valley was $5450 and the worksheet attached in support of this calculation did not revise the Medicaid fraction and increased the Medicare fraction from 2.3870 percent to 2.490 percent; however, it gave no explanation as what revisions were being made to cause this increase (*e.g.*, removing certain days from the denominator or adding certain days to the numerator or some combination thereof).

In the EJR request filed for Case No. 17-0554GC, QRS represents the issue in the CIRP group as follows:

Quality Reimbursement Services, Inc. ("QRS" or "Provider") as the designated representative for the above referenced group appeal, requests Expedited Judicial Review be granted for the following reasons:

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 and included in the Medicaid fraction and accordingly has granted EJR on this issue.

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** [*sic*] unpaid (i.e., 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 specific issue is whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "**dual eligibles"), and for whom Medicare has not made a payment** for that inpatient stay (hereinafter referred to as "non-covered days"), should be included in the Medicare fraction of the Medicare Disproportionate Share (DSH) 2 adjustment, as alleged by the MAC, or **should be excluded from the Medicare fraction of the DSH adjustment, and instead be included in the Medicaid fraction, as alleged by the providers**.[5]

[5] EJR Request at 1, 2-3 (Mar. 13, 2020) (bold and underline emphasis added.)

III. Board Decision:

The Board notes, initially, that it has full power and authority to make rules and establish procedures which are necessary or appropriate to conduct its affairs.[6] To this end, the Board has exercised that discretion to require that, following full formation of a group, the representative file a final schedule of providers ("SoP") with supporting jurisdictional documentation. The SoP is critical for determining the Board's jurisdiction over the group and each of the underlying participants in a group as affirmed by the Secretary in the preamble to the final rule published on May 23, 2008:

> *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 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.[7]

Board Rule 20 addresses the procedures for SoPs and the associated supporting jurisdictional documentation in group appeals. The Board includes the following excerpts from the Board Rules (Aug. 2018) as they are relevant to this discussion of the purpose behind the SoP and the documentation required to demonstrate jurisdiction over each participant listed in the group:

- Board Rule 20.1 states, in relevant part: "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)."[8]

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[6] 42 U.S.C. § 1395oo(e). *See also* 42 C.F.R. §§ 405.1868(a), (b)(3), (c); 405.1853(b)(3), (c)(3)(i).
[7] 73 Fed. Reg. 30190, 30212 (May 23, 2008) (emphasis added).
[8] (Emphasis added.)

- The Commentary to Board Rule 20.2 states, in relevant part:

> *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.[9]

- Board Rule 21 states: "*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."[10]

- Board Rules 21.2, 21.3 and 21.8 stating:

> **21.2 Date of Final Determination**
>
> **21.2.1 Schedule – Column A**
>
> List date of final determination. If the final determination being appealed is a revised NPR, include an "(R)" after the date.
>
> **21.2.2 Documentation – Tab A**
>
> A copy of the final determination you are appealing:
>
> • For a NPR appeal, submit the dated NPR cover page(s). Do not submit the entire NPR.

[9] (Emphasis added.)
[10] (Emphasis added.)

- For a revised NPR appeal, submit the dated revised NPR cover page(s). Do not submit the entire revised NPR. *See* Rule 7.1.2.1 for additional documentation requirements for appeals filed from a revised NPR.
- For appeals of other final determinations (e.g., exception and exemption denials, Federal Register notices, Quality Reporting reconsideration denials, etc.), submit a copy of the final determination being appealed. (*See* Rules 7.1.2.2 – 7.1.2.5.)
- For appeals of the Medicare contractor's failure to timely issue an NPR, submit a copy of:

  - evidence of the Medicare contractor's receipt of the as-filed or amended cost report under appeal, and
  - evidence of the Medicare contractor's acceptance of the as-filed or amended cost report under appeal. (*See* Rule 7.5.)

21.3 Date of Hearing Request

21.3.1 Schedule – Column B

Enter the date on which the original hearing request was filed with the Board (see Rule 4.3). If the issue under appeal was added to the individual appeal subsequent to the original appeal request (*see* Rule 6.2.1), also enter the date that the request to add the issue was filed.

- If the appeal request was filed prior to August 21, 2008, the date of filing is the postmark date. *See* 42 C.F.R § 405.1801(a)(2007).
- If the appeal request was filed on or after August 21, 2008, the date of filing is the date of receipt by the PRRB. *See* 42 C.F.R. § 405.1801(a)(2008).

21.3.2 Documentation – Tab B

A copy of the relevant pages from the initial appeal request (Model Form A or E) and the request to add an issue, if applicable (Model Form C), including the issue statement, or other written requests filed prior to the use of such Model Forms in which this issue was appealed for the first time. In addition, if the appeal was filed after August 21, 2008, include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue.

* * * *

21.8 Dates of Direct Add/Transfer

21.8.1 Schedule – Column G

For each case number identified in Column F, *identify the date the issue was transferred from each respective case to the next case in order to identify* ***the full history of transfers***. The transfers must be identified in chronological order (earliest to latest).

21.8.2 Documentation – Tab G

The letter or Model Form transferring the issue from the individual appeal to a group appeal, ***as well as any subsequent transfer to a second or third group must be placed under this tab***. If the cases were restructured, include a copy of the request to restructure and the Board's letter restructuring the case. The letters should be placed under the tab in chronological order (earliest to latest) to correspond with the schedule of providers. The dates of the letter(s) must match the dates recorded in column G of the schedule of providers. (See Rules 16, 17 and 18.)

Finally, 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.[11]

A. Dismissal of Case No. 17-0554GC In Its Entirety For Failure of QRS To Comply With Board Rules, the Board Orders Dated November 30, 2020 and January 21, 2021, and Improperly Listing 10 Participants Either Without Leave of the Board or Based On Patently False Representations and Factual Impossibilities.

The revised SoP filed by QRS on February 22 2021 listed 16 participants in Case No. 17-0554GC. *As explained below, the Board is exercising its authority under 42 C.F.R. § 405.1868(a)-(b) to dismiss the* ***entirety*** *of Case No. 17-0554GC for failure of QRS to follow Board Rules governing SoPs and the Board's Orders dated November 30, 2020 and January 18, 2021, and for* ***improperly listing 10 of the 16 participants*** *on the revised SoP either: (a)* ***without leave of*** *(or notice to)* ***the Board****; or (b) based on* ***patently false*** *representations* ***and*** *factual* ***impossibilities***. In addition, the Board has set forth in Section III(B) alternative bases for dismissal of Case No. 17-0554GC.

1. Dismissal of Case No. 17-0554GC In Its Entirety Based on QRS Failure to Comply with Board Rules Governing SoPs and the Board's Order Dated January 21, 2021

For Case No. 17-0554GC, QRS certified the group was complete and simultaneously filed the final SoP on March 3, 2020. By letter dated November 30, 2020, the Board required QRS to

[11] 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 added.)

submit a revised SoP for Case No. 17-0554GC with the addition of certain specified information/documentation:

> In reviewing the Schedules of Providers and associated jurisdictional documentation in both Case Nos. 15-3123GC and 17-0554G, the Board notes that the jurisdictional documentation was missing required information. Consequently, the Group Representative is to revise the Schedule of Providers to include the missing information and resubmit the Schedules of Providers. In both the Group Representative failed [*sic* to] include Model Form B-Group Appeal Request under Tab B for the Provider that was used to establish the group and which also includes a statement of the issue that was appealed. A complete copy of Model Form B is to be placed under Tab B for the Provider that was used to establish the group appeal, along with the proof of receipt by the Board. Model Form B will include Model Form B, a schedule or list of the Provider(s) used to establish the group, Model Form E (request to join the group) and the statement of the issue. . . . In a group appeal, Model Form B-Request for a Group Appeal must be included under Tab B to demonstrate that at least one Provider in every group has actually appealed the issue it is allegedly challenged and for which it (and the other members of the group) is seeking resolution by the Board. Board Rule 21.3.2 also requires that proof [*sic* the Representative] include a copy of the proof of delivery (e.g., USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue be included under Tab B as the last document under that Tab.
>
> ***Within 30 days of this letter's signature date***, the Group Representative must resubmit the Schedule of Providers and associated jurisdictional documents so that Model Form B is included in each set of jurisdictional documents so that the Board can review the issue that was appealed to ascertain whether the issue reflects the subject of the EJR request. The Board needs this information so that it may complete its jurisdictional review in both cases.

By letter dated January 21, 2021, the Board renewed the mandate that QRS was to submit a revised SoP for Case No. 17-0554GC and expanded the items that QRS was to include in the revised SoP:

> Once again, the Board is asking the Group Representative to submit a paper copy of the Schedule of Providers and associated jurisdictional documents in Case No. 17-0554GC as revised by consolidation of 15-3123GC into 17-0055GC and, if timely

requested, the transfer of Deaconess Hospital (Prov. No. 50-0044, FYE 12/31/2005) from Case No. 17-1412G to 17-0554GC.

Further, in reviewing the Schedules of Providers and associated jurisdictional documentation in both Case Nos. 15-3123GC and 17-0554G, the Board notes that the jurisdictional documentation was missing required information as described below. Consequently, the Group Representative is to revise the Schedule of Providers in the remaining case, 17-0554GC to include the missing information and resubmit the Schedule of Providers.

In both Case Nos. 17-0544GC and 15-3123GC, the Group Representative failed to include Model Form B-Group Appeal Request under Tab B for the Provider which was used to establish each of these two CIRP groups and which also includes a statement of the issue that was appealed for the CIRP group. A complete copy of Model Form B is to be placed under Tab B for the Provider that was used to establish the Case No. 17-0554GC, along with the proof of receipt by the Board. Similarly, a copy of the original hearing request used to establish Case No. 15-3123GC, should be placed under Tab B for Valley Hospital Medical Center (Prov. No. 50-0119, FYE 9/30/2008) (the Board recognizes that this original hearing request may not include Valley Hospital Medical Center). Model Form B will include Model Form B, a schedule or list of the Provider(s) used to establish the group, Model Form E (request to join the group) and the statement of the issue and proof of receipt by the Board.

* * * *

In a group appeal, Model Form B-Request for a Group Appeal must be included under Tab B to demonstrate that at least one Provider in every group has actually appealed the issue it is allegedly challenged and for which it (and the other members of the group) is seeking resolution by the Board. Board Rule 21.3.2 also requires that proof [*sic* the Representative] include a copy of the proof of delivery (*e.g.*, USPS, FEDEX or UPS tracking) for both the original appeal request and the addition of the issue be included under Tab B as the last document under that Tab.

Consequently, the Board requires that the Group Representative file the information identified above ***within 30 days of this letter's signature date***.[12]

[12] (Emphasis in original and footnote omitted.)

On February 22, 2021, QRS filed a revised SoP to: (a) add in the complete copy of the group appeal request for Case No. 17-0554GC (including proof of delivery) behind Tab B for the Provider that was used to establish that CIRP group; and (b) reflect the Board's planned consolidation of Case No. 15-3123GC into 17-0554GC by adding Valley Hospital Medical Center ("Valley") for FY 2008 as participant.

It has come to the Board's attention that: (1) the revised SoP includes changes outside of those requested by the Board, including the addition of 6 new participants even though the final SoP had been filed on March 3, 2020; (2) QRS *failed* to obtain leave of the Board to make those changes; and, (3) *failed* to give notice to the Board, and the opposing party, of those additional changes.

a. *Improperly Added 2 Participants, Namely Participant ##3.1 and 3.3*.—QRS added Participant ##3.1[13] and 3.3[14] to the final SoP.[15] However, QRS did not seek (nor did the Board grant) leave to add any participants to the final SoP, beyond Valley FY 2008. QRS failed to notify the Board and the opposing party that these additions had been made, and failed to explain why it has any basis to add them at this late stage. Thus, to the extent Participant ## 3.1 and 3.3 should have been part of the group (*i.e.*, these participants had proper appeals and additions to the CIRP group), it is clear that QRS failed to list these participants on the March 3, 2020 final SoP and, accordingly, the Board considers them abandoned and not part of Case No. 17-0054GC. Moreover, as explained below, QRS' addition of them was based on ***patently false*** representations.

b. *Improperly Added New Supporting Jurisdictional Documentation for Participant #4.0*.—In the revised SoP, QRS included additional jurisdictional documentation for Participant #4.0. Behind Tab 4.0D, the final SoP only had a single page stating "Self-Disallowed." In the revised SoP, QRS removed that single page and replaced it with pages 3 and 4 from the Audit Adjustment Report dated March 25, 2008. QRS did not have leave of the Board to make this change and it failed to notify the Board and the opposing party of this change.

c. *Improperly Adding 4 Participants, Namely Participant ##5.1, 5.2, 5.3, and 5.4*.—On the final SoP for Case No. 15-3123GC, QRS listed two participants: Participant #1, Deaconess Medical Center for FY 2012 based on the appeal of an NPR dated June 29, 2012 ("Deaconess FY 2012"); and Participant #2, Valley Hospital Medical Center for FY 2008 based on a transfer from the individual appeal of an NPR dated August 10, 2012 in Case

[13] QRS listed Participant #3.1 on the revised SoP and included supporting jurisdictional documents behind new Tabs 3.1B, 3.1D, 3.1E and 3.1H.
[14] QRS listed Participant #3.3 on the revised SoP and included supporting jurisdictional documents behind new Tabs 3.3A, 3.3B, 3.3D, 3.3E and 3.3H.
[15] The final SoP (*i.e.*, the one filed on March 3, 2020) included Participant ##3.0 and 3.1. In the revised SoP (*i.e.*, the one filed on February 22, 2021), Participant #3.0 remained Participant #3.0 while QRS renamed Participant #3.1 as Participant #3.2 and then added in Participant ## 3.1 and 3.3. The Board notes that QRS failed to notify the Board and the opposing party that it had renamed Participant 3.1 as Participant 3.2 and then added Participant #3.1 and Participant 3. Indeed, none of these changes to the final SoP were flagged for the Board and the opposing party.

No. 13-0059 ("Valley FY 2008").[16] By letters dated November 30, 2020, the Board notified QRS that Deaconess FY 2012 was improperly listed on the SoP and reaffirmed that finding by letter dated January 21, 2020.[17] Accordingly, as there was a single participant in Case No. 15-3123GC, the Board proposed consolidating Case No. 15-3123GC into Case No. 17-0054GC and, thus, gave leave to QRS to add the *sole* participant, Valley FY 2008, to the revised NPR. However, rather than just adding the ***single*** Participant #2 from Case No. 15-3123GC as listed on the SoP for that CIRP group, QRS added ***5 different*** participants labeled as Participant ##5.0, 5.1, 5.2, 5.3, and 5.4, ***falsely*** representing that Valley FY 2008 had 5 ***separate and independent*** bases to be a participant in Case No. 17-0554GC even though it only had leave of the Board to add a single participant to the final SoP as opposed to the 5 listed. The Board notes that it never effectuated the consolidation of Case No. 15-3123GC into 17-0554GC because it instead dismissed Case No. 15-323GC in its entirety by letter dated April 21, 2022 since it was a prohibited duplication of 15-3126GC for which the Board had already granted EJR on the same issue and year for Empire Health.[18] Accordingly, Participant ##5.0 through 5.4 were never part of this CIRP group and the Board need not further address them.

The Board reprimands QRS for making alterations, outside of the Board's November 30, 2020 and January 18, 2021 Orders, and adding 6 participants to the final SoP without leave of the Board and for its failure to notify the Board and the opposing party (e.g. via an errata sheet) of those alterations.

2. *QRS Improperly Lists 4 Participants On the SoP Dated February 22, 2021 Based On* ***Patently False*** *Representations And Factual* ***Impossibilities***

The Board further reprimands QRS for making patently false representations *that the following participants are part of this CIRP group appeal when it was* ***factually impossible*** *based on the documentation provided (which does* ***not*** *include basic documentation of either the participant requesting transfer or direct add* ***to Case No. 17-0554GC*** using Model Forms D and E respectively*)*. The Board finds that, as described below in detail, it was a ***factual impossibility*** for any of the following participants to ever be a part of Case No. 17-0554GC based on the representations made and the documentation supplied by QRS:

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[16] By letter dated March 3, 2020, QRS certified that Case No. 15-3123GC was fully formed and submitted the final SoP with supporting documentation. The final SoP was prepared on July 12, 2019.

[17] The Board's letter dated November 30, 2020 documents that: (1) on February 23, 2016, the Board had dismissed Valley's individual appeal under Case No. 13-0041 in its entirety and, as a result, denied a transfer from Case No. 13-0041; and (2) in response to a request for reconsideration dated March 14, 2016, the Board reaffirmed its dismissal of Case No. 13-0041, by letter dated June 17, 2016. At that point in time, the Board had not received the Administrator's remand order for Case No. 13-0041. Following receipt of that remand, the Board reopened Case No. 13-0041 and dismissed the dual eligible days issue because QRS had already pursued the dual eligible days issue on behalf of Empire Health for FY 2012 as part of Case No. 15-3126GC and, indeed, at that time, QRS had its appeal of that issue pending before the Supreme Court and is part of the following Supreme Court decision issued on June 27, 2022: *Becerra v. Empire Health Foundation*, No. 20-1312, 2022 WL 2276810 (S. Ct. 2022), *reversing*, 958 F.3d 873 (9th Cir. 2020).

[18] *See supra* note 17.

a. *Participant #2.0—Deaconess's FY 2007 appeal based on the NPR dated July 30, 2009 ("Deaconess 2.0")*—In the SoP, QRS represents that Deaconess 2.0 was a "direct file" based on the appeal of an original NPR dated July 30, 2009 and that the date of the direct add to Case No. 17-0554GC was November 23, **2009** and that:

> QRS was unable to locate ***the delivery*** of the Model Form E. The date provided under Tab B is the date the Model Form E *was sent* to the Board.[19]

Behind Tab 2.0(B) is the referenced Model Form E dated November 8, **2009** requesting that the provider be added to Case No. 09-2071GC (as opposed to the instant CIRP group, Case No. 17-0554GC). Thus, contrary to the representations on the SoP, this participant was **NOT** a "direct file" to Case No. 17-0554GC on or about November 8, **2009**. Indeed, that allegation is **a *factual impossibility*** since Case No. 17-0554GC was not established or in existence ***until over 7 years later*** on November 30 2016 when QRS filed the group appeal request to establish Case No. 17-0554GC.[20,21] Accordingly, QRS' representation that Deaconess 2.0 was *directly added* to Case No. 17-0054GC is, on its face, ***patently false***.[22]

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[19] (Emphasis added.)

[20] *See* Board Rule 4.7.2.2 (Aug. 2018) (previously located at Board Rule 4.6(B)(2) in the Board Rules issued in July 2009); Board Rule 17 (July 2009) ("The Board will not grant a request to transfer from a group case to another case except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation or common issue requirements. *The motion* ***must*** also ***include*** *fully executed* ***Model Form D*** (Transfer Form) and Model Form A as appropriate. *No transfer from a group to another case is effective* ***unless the transfer request is approved by the Board***." (emphasis added)).

[21] Even putting aside the ***patently false*** representation that Deaconess 2.0 FY 2007 was directly added to Case No. 17-0554GC, there are other problems with their representation, including (1) QRS admits that it failed to provide ***any*** proof of filing of the Model Form E as required by Board Rule 21.3.2; (2) the letter of representation dated September 4, 2012 at Tab 2.0H was not obtained until nearly 3 years after QRS alleges it filed the Model Form E ("The date provided under Tab B [i.e., Nov. 23, 2009] is the date the Model Form E was sent to the Board") and, as such, QRS filing of the alleged Model Form E would be invalid and void, particularly since the authorization in the Model Form E itself was only authorization to file in Case No. 09-2071GC (as opposed to Case No. 17-0554GC); and (3) even if QRS were to later assert that there was a group-to-group transfer from Case No. 09-2071GC to Case No. 17-0554, such a transfer could ***only*** occur if the Provider requests that the Board approve that transfer ***and*** then the Board actually approves that transfer (*see supra* note 20); however, QRS had neither made that assertion nor has it provided the requisite documentation to support such an allegation consistent with the requirement of the SoP to provide all documentation needed to establish jurisdiction for each participant. As required in Board Rule 21.8.2, QRS would have needed to provide the "full history of transfers" to document step-by-step how it got transferred from Case No. 09-2071GC into Case No. 17-0554GC and that history has not been provided. Indeed, such a transfer would be a ***factual impossibility*** since Case No. 09-2071GC was closed in February 2015 well more than a year prior to Case No. 17-0554GC being established in November 2016, as discussed more fully in *infra* note 25.

[22] It is unclear why Deaconess 2.0 did not appeal the Secretary's policy to include no-pay Part A days in the Medicare fraction and exclude the subset of those days pertaining to dual eligibles from the Medicaid fraction. However, the Board notes that Deaconess 2.0 apparently ***did*** appeal from its original NPR the ***exclusion*** of no-pay Part A days from both the Medicare and Medicaid fractions because it is listed as a Participant #4 in the Board's decision under PRRB Dec. No. 2018-D43 (July 5, 2018) for Case No. 08-2895GC wherein that class of days was at issue.

b. *Participant #3.0—Valley FY 2005 based on the appeal request dated 01/17/2009 NPR dated 9/19/2007 ("Valley 3.0")*— In the SoP, QRS represents that Valley 3.0 was transferred from Case No. 08-0905 to Case No. 17-0554GC on December 9, 2010 using a Model D Form and that:

> QRS was unable to locate ***the delivery*** of the Model Form D. The date provided under Tab B is the date the Model Form E *was sent* to the Board.[23]

Behind Tab 3.0(B) is Valley 3.0's individual appeal request dated January 17, 2009, that established Case No. 08-0905 and, as evidence to support the transfer of Valley 3.0 from Case No. 08-0905 to Case No. 17-0554GC behind Tab 3.0(G), is Valley 3.0's transfer request dated December 9, 2010 to Case No. 09-2071GC (as opposed to the instant CIRP group, Case No. 17-0554GC). Thus, contrary to the representations on the SoP, this participant was **NOT** transferred from Case No. 08-0905 to Case No. 17-0554GC on or about December 9, **2010**. Indeed, that allegation is **a *factual impossibility*** since: (1) Case No. 17-0554GC was not established ***until nearly 6 years later*** on November 30 2016;[24,25] and (2) Case No. 08-0905 was withdrawn on or about January 10, 2011 (resulting in case closure), *over 5 years* ***prior to*** Case No. 17-0554GC being established on November 30, 2016. Accordingly, QRS' representation that Valley 3.0 is a participant Case No. 17-0054GC based on a transfer from Case No. 08-0905 to Case No. 17-0554GC is ***patently false***.[26]

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[23] (Emphasis added.)

[24] *See* Board Rule 4.7.2.2 (Aug. 2018) (previously located at Board Rule 4.6(B)(2) in the Board Rules issued in July 2009); Board Rule 17 (July 2009) ("The Board will not grant a request to transfer from a group case to another case except upon written motion demonstrating that the group failed to meet the amount in controversy upon full formation or common issue requirements. *The motion* ***must*** also ***include*** *fully executed* ***Model Form D*** (Transfer Form) and Model Form A as appropriate. *No transfer from a group to another case is effective* ***unless the transfer request is approved by the Board***." (emphasis added)). Further, Board Rule 21.8.2 required that the "***full*** history of transfers" be documented in the SoP. (Emphasis added.)

[25] Even putting aside the ***patently false*** representation that Valley 3.0 FY 2007 was directly added to Case No. 17-0554GC, there are other problems with their representation, including: (1) QRS admits that it failed to provide any proof of filing of the Model Form D transfer request dated December 9, 2010 as required by Board Rule 21.8; (2) the alleged transfer to Case No. 17-0554GC would be invalid/void because it allegedly occurred almost 6 years prior to it obtaining the requisite authorization from the client as documented in the letter of representation dated November 23, 2016 and the authorization in the Model D Form only permitted transfer to Case No. 09-2071GC; and (3) it is unclear from the record before the Board what issue Case No. 09-2071GC involved because QRS failed to provide a complete transfer history per Board Rule 21.8 and include a complete copy of Model Form G which would include a copy of the group issue statement attached thereto for Case No. 09-2071GC; and (4) even if QRS were to later assert that there was a group-to-group transfer from Case No. 09-2071GC to Case No. 17-0554GC, such a transfer could ***only*** occur if the Provider requests that the Board approve that transfer and then the Board actually approves that transfer (*see supra* notes 20, 21); however, QRS had neither made that assertion nor has it provided the requisite documentation to support such an allegation consistent with the requirement in Board Rule 21.8 to provide the "full history of transfers" and the general SoP requirement in Board Rules 20.1 and 21 to provide all documentation needed to establish jurisdiction for each participant.

[26] *Even if there had been a valid transfer request filed*, the Board's review of the individual appeal request for Valley 3.0 demonstrates that the issue for which the Providers are seeking EJR in Case No. 17-0554GC was ***not*** part of that appeal request and, as such, Valley 3.0 would have had no basis to even make a valid request to transfer from

c. *Participant #3.1—Valley FY 2005 based on the add issue statement allegedly filed in the individual appeal under Case No. 08-0905 based on the NPR dated 9/19/2007 ("Valley 3.1")*— In the SoP, QRS represents that Valley 3.1 filed an add issue request dated October 13, 2008 and transferred an added issue therein from Case No. 08-0905 to Case No. 17-0554GC on an unspecified date and refers to the document behind Tab 3.1(B). The document behind Tab 3.1(B) is simply the request to add issues dated October 13, 2008. Significantly, contrary to the requirements of Board Rule 21.3.2, QRS fails to provide any documentation behind Tab 3.1(B) establishing that the alleged add-issue request was actually filed in Case No. 08-0905 (nor does QRS recognize that it failed to

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Case No. 08-0905 to Case No. 17-0554GC based on the appeal request. Issue 4 is the only issue in the appeal request that directly addresses no-pay Part A days included in the SSI fraction:

> From the inception of the DSH adjustment in 1986, CMS stated that the SSI fraction would include days paid by Medicare, consistent with CMS' original policy regarding the composition of the Medicaid fraction before the issuance of HCFA Ruling 97-2. *See, e.g.*, 51 Fed. Reg. 31454, 31460 (Sep. 3, 1986). In defending its original policy concerning the Medicaid fraction, CMS represented to several federal courts that the Medicare/SSI fraction counts only Medicaid paid days. *See, e.g., Legacy Emanuel Hospital & Health Center v. Shalala*, 97 F.3d 1261, 1265 (9th Cir. 1996).
> The Provider has data identifying patients eligible for both Medicare Part A, and Title XIX benefits. ***Medicare did not make payment on behalf of these patients***. ***Due to the absence of a Medicare payment*** *CMS failed to consider these patients in the determination of the Providers SSI percentage*. The Intermediary ***failed to include*** these patients in the Providers Medicaid Proxy because the patients were eligible for Part A benefits. *Thus, these patients have been* ***excluded from*** *the numerator and denominator of* ***the SSI percentage*** *calculation* ***and from the numerator of the Medicaid Proxy***. The provider seeks recognition of these patient days and asks the Board to decide whether they should be included in the SSI percentage calculation or the Medicaid Proxy.

(Emphasis added.) As such, it is clear that this issue relates to no-pay Part A days excluded from ***both*** the Medicare fraction and Medicaid fraction (which is a different class of days than that at issue in this case, namely the no-pay Part A days ***included*** in the Medicare fraction). It is the Board's understanding that this issue was transferred to Case No. 08-2955GC for which the Board issued Dec. No. 2018-D43. The other issues in the appeal request also clearly do ***not*** pertain to the issue for which the Provider requested EJR as they were Issue 1 for "Disproportionate Share – Medicaid Eligible Patient Days – State Only"; Issue 2 for "Disproportionate Share – SSI Percentage"; Issue 5 for "Capital Payments." The Board notes that it was Issue 2 relating to the "Disproportionate Share – SSI Percentage" that was transferred to Case No. 09-2071GC. Regardless of the scope of that group issue statement, a provider can ***only*** transfer from an individual appeal what it has appealed in the first instance and, here, Issue 2 only related to the "findings of the PRRB in Baystate" (*i.e.*, *Baystate Med. Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). Neither the issue statement for Issue 4 nor the Board's decision in *Baystate* discuss the exclusion of no-pay Part A days from the Medicare fraction and inclusion of such days in the Medicaid fraction to the extent they were dual eligible days. Indeed, the fiscal years at issue in *Baystate* were FYs 1993 to 1996, well before the Secretary issued the FY 2005 IPPS final rule to change its policy from a policy that excluded any no-pay Part A days (including those for dual eligibles) from both the Medicare and Medicaid fractions to a policy that include all no-pay Part A days (including those for dual eligibles) in the Medicare fraction. Regardless, QRS has not included in the record any group-to-group transfer request to transfer from Case No. 09-2071GC to Case No. 17-0554GC or the requisite Board approval of that group-to-group transfer because, as previously noted, Board Rule 21.2.8 requires documentation of the "full history of transfers." *See supra* notes 20, 21. Indeed, such a transfer would be a ***factual impossibility*** since: (1) the Board remanded and closed Case No. 09-2071GC on October 22, 2015; (2) the Board never reinstated Case No. 09-2071GC after that date in order to take any actions (*e.g.*, permit a transfer); (3) the closure of Case No. 09-2071GC occurred more than a year ***prior to*** QRS filing the group appeal that established Case No. 17-0554GC on November 16, 2016.

provide that proof of filing documentation[27]). Further, even though required by Board Rule 21.2.8, QRS failed to include any documents at Tab 3.1(G) to show or establish that Valley 3.1 transferred from Case No 08-0905 to Case No. 17-0554GC. In fact, such a transfer is a ***factual impossibility*** since the Board closed Case No. 08-0905 based on receipt of the Provider's withdrawal request on or about January 10, 2011, well before QRS filed the group appeal request to establish Case No. 17-0554GC on November 30, 2016.[28] Finally, the Board notes that the SoP line for Valley 3.1 references a "Model Form E – Appeal Dir to Grp" (*i.e.*, a direct add request to join a group). However, QRS fails to include any such documentation for Valley 3.1 and, regardless, it would have been ***a factual impossibility*** since the time to directly add to the group based on an appeal of the January 17, 2009 NPR had well since expired *prior to* the establishment of Case No. 17-0554GC on November 30, 2016.[29] Based on the above facts, it is clear that QRS' claim that Valley 3.1 is a participant in Case No. 17-0554GC, based on a transfer from Case No. 08-0905 to Case No. 17-0554GC, is ***patently false***.

d. *Participant #4.0—Valley FY 2006 based on original NPR dated 4/15/2008 ("Valley 4.0")*—In the SoP, QRS represents that Valley 4.0 filed an individual appeal request on October 6, 2008 to establish Case No. 09-0109 and that, on July 16, 2009, Valley 4.0 transferred from Case No. 09-0109 to Case No. 17-0554GC. However, with regard to the alleged transfer, QRS includes a footnote stating "QRS was unable to locate the delivery notification of the Model Form D. The date provided under Tab G is the date the Model Form D was sent to the Board." First, the Board notes that QRS' documentation at Tab 4.0(G) does not establish that the transfer request included behind Tab 4.0(G) was, in fact, filed with the Board. More significantly, the alleged transfer from Case No. 09-0109 to Case No. 17-0554GC is ***a factual impossibility*** because the transfer request dated July 14, 2009 was allegedly filed more than 7 years ***prior to*** QRS filing the group appeal request to establish Case No. 17-0554GC on November 30, 2016. Furthermore, Valley 4.0 filed a withdrawal of Case No. 09-0109 on or about April 20, 2011, more than 5 years prior to QRS' establishment of Case No. 17-0554GC on November 30, 2016. Also, the transfer request form does not include the group case name or number to which the issue was being transferred because it was "not yet assigned" and gave the date of the group appeal request as July 17, 2009 (which again is more than 7 years prior to when the group appeal request

[27] In other instances where QRS did not include proof of filing documentation, QRS has added footnotes 2 and 3 on the SoP denoting that it "was unable to locate the delivery notification."

[28] The Board notes that, with respect to Valley 3.1, the SoP did not reference Case No. 09-2071GC. To the extent QRS were to later claim it should, then the Board discussion in *supra* note 26 would be relevant. Moreover, similar to Participant ##2.0 and 3.0, there are issues with the letter of authorization furnished for Participant #4.0. Specifically, the letter of representation provided behind Tab 4.0H is dated June 3, 2013 almost 4 years after the transfer alleged in Column G of the revised SoP (note the provider authorization in the Format at Tab 4.0G only provides authorization to transfer to Case No. 09-2071GC). Accordingly, QRS did not have authorization from the Provider to make the alleged transfer.

[29] Case No. 08-0905 was established in January 2008 and the Provider had until Monday, October 20, 2008 to add issues. *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 (implementing the final rules instruction on adding issues for cases that were then pending before the Board).

> for the instant case was filed on November 30, 2016). Based on the above findings, it is clear that QRS' representation that Valley 4.0 is a participant in Case No. 17-0554GC, based on a transfer from Case No. 09-0109 to Case No. 17-0554GC, is ***patently false***.[30]

Again, the Board reprimands QRS for: (a) ***failing to comply with Board Rules governing SoPs and making patently false representations*** *that Participant ##2.0, 3.0, 3.1 and 4.0 were part of this CIRP group appeal when it was* ***factually impossible*** *based on the documentation provided;* ***and*** (b) ***altering its prior final SoP by adding 6 participants and other documentation without leave of the Board*** *(i.e., for making alterations outside of the scope of the Board's November 30, 2020 and January 18, 2021 orders)*; ***and*** (c) ***failing to notify the Board and the opposing party of those alterations*** *(e.g., by not including an errata sheet)*. As a result of these violations, it is clear that QRS ***improperly*** added 10 of the 16 participants listed on the revised SoP filed on February 22, 2021. The Board takes administrative notice that QRS has a very large docket of pending cases before the Board (currently around 1500 groups cases alone) and has been appearing before the Board for many years. As a result, QRS should be familiar with Board Rules governing SoPs, and its basic responsibilities as a representative, including *ensuring due diligence is exercised* ***prior to*** *making filings*.

Given the serious nature of QRS' violations of Board Rules and Board Orders, as well as the pervasiveness of those violations and misrepresentations, it is clear that, at a minimum, QRS has ***acted with reckless disregard*** *for its basic responsibilities as a representative appearing before the Board; specifically failing to exercise due diligence*. The Board is deeply troubled by QRS' serious violations and cannot permit them to remain unanswered. *Accordingly, a severe punitive remedy is warranted and, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b),*[31] ***the Board dismisses Case No. 17-0554GC in its entirety***. The severity of the Board remedial action is well within the Board's authority under 42 C.F.R. § 405.1868(a)-(b), 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

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[30] *See also supra* notes 20, 21 discussing the evidence required to establish participation in a group based on a group-to-group transfer.

[31] 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.)

> 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 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.[32]

B. Alternative Bases for Dismissing the Other Participants, Not Named in Section III(A), as Being Improperly Listed on the SoP.

1. Participant #3.3 must be dismissed as a duplicate of Participant #3.2

> Participant #3.2 – Valley Hospital Medical Center, Prov. No. 50-0119, FY 2005
> Participant #3.3 – Valley Hospital Medical Center, Prov. No. 50-0119, FY 2005

Participant #3.2 and Participant #3.3 are duplicative because: (a) they pertain to the same provider for the same fiscal year; (b) their participation in Case No. 17-0554GC is based on their appeal of the same revised NPR dated June 3, 2016 (copy included at Tabs 3.2A and 3.3A); and, (c) they were added to the group based on the same Model Form E direct add request dated November 23, 2016 (copy included at Tabs 3.2B and 3.3B). Accordingly, as an alternative basis for dismissal,[33] the Board dismisses Participant #3.3 as a prohibited duplicate of Participant #3.2.

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[32] 73 Fed. Reg. at 30225.

[33] The Board dismissed Participant #3.3 in Section III(A)(1) because it was added without leave of the Board. In addition, in Section III(A), the Board dismissed Case No. 17-0554GC in its entirety pursuant to 42 C.F.R. § 405.1868(a)-(b).

2. *Participant ##1.0, 2.2 and 4.2 must be dismissed as the Board Lacks Jurisdiction over their appeal pursuant to 42 C.F.R. §§ 405.1889(b) as referenced in 42 C.F.R. § 405.1835(a).*

> Participant #1.0 – Deaconess Medical Center, Prov. No. 50-0044, FY 2005
> Participant #2.2 – Deaconess Medical Center, Prov. No. 50-0044, FY 2007
> Participant #4.2 – Valley Hospital Medical Center, Prov. No. 50-0119, FY 2006

Participant ##1.0, 2.2, and 4.2 each appealed a revised NPR dated December 7, 2018 and the audit adjustment report associated with ***each*** of their revised NPRs (copy at Tabs 1.0D, 2.2D, and 4.2D respectively) confirms that the revised NPR was issued "[t]o adjust the cost report to include the hospital's Realignment SSI percentage as calculated by CMS."

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 toboth Medicare Part A (including Medicare Advantage (Part C)) and SSI, excluding those patients who received only State supplementation;
>
> (ii) Adds the results for the whole period; and
>
> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[34]

The data matching process by which CMS gathers this monthly data is described in the FY 2011 IPPS Final Rule.[35] 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

[34] (Emphasis Added.)
[35] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).

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***.[36]

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."[37]

Accordingly, the realignment process does not change ***any*** of the data underlying the realigned SSI fraction (*e.g.*, did not adjust no-pay Part A days or dual eligible 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 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 since the previously-gathered month-by-month data remains unchanged). Indeed, as noted in the second Federal Register excerpt included above, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

Since the only matter specifically revised in the revised NPRs at issue were an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, Participant

[36] (Emphasis Added.)
[37] (Emphasis Added.)

##1.0, 2.2 and 4.2 do not have a right, under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1), to appeal those revised NPRs for the issues covered by the EJR request. Accordingly, as an additional basis for dismissal,[38] the Board dismisses Participant ##1.0, 2.2, and 4.2 for lack of jurisdiction. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[39]

3. *Participant ##1.0 and 3.2 must be dismissed pursuant to 42 C.F.R. § 405.1837(b(1)(i) because Empire Health is pursuing the common issue for FY 2005 in another group appeal*.[40]

By letter dated January 21, 2021, the Board notified QRS that Participant 1.0, Deaconess Medical Center for FY 2005 was a participant in an *optional* group under Case No. 17-1412G and required that QRS transfer Deaconess within 15 days to Case No. 17-0554GC:

> A review of the Office of Hearings Case and Document Management System was conducted in conjunction the examination of the Schedule of Providers and associated jurisdictional documents submitted in Case No. 17-0554GC. The Board notes that Provider # 1, Deaconess Medical Center (Prov. No. 50-0044, FYE 12/31/2005) has multiple appeals of the same issue for the same fiscal year:
>
> (1) On May 28, 2019, it directly joined the CIRP group under Case No. 17-0554GC for FY 2005 based on an appeal of its ***revised*** Notice of Program Reimbursement for FY 2005 dated December 7, 2018.
>
> (2) On January 9, 2017, it appealed its ***original*** NPR for FY 2005 to establish the individual case under Case No. 17-0802 and, on May 21, 2018, transferred Medicaid Fraction Dual Eligible Days to the optional group under Case No. 17-1412G entitled the "QRS 2005 DSH Medicaid Fraction Dual Eligible Days Group."
>
> The regulation, 42 C.F.R. § 405.1837(b), requires that commonly owned providers file a group appeal of an issue that is common to the providers and arises in the same calendar year. . . .

[38] In addition, in Section III(A), the Board dismissed Case No. 17-0554GC in its entirety pursuant to 42 C.F.R. § 405.1868(a)-(b).

[39] *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).

[40] This alternative basis for dismissing Participant #3.2 applies equally to Participant #3.3 were it not a prohibited duplicate of Participant of #3.2.

Further, Board Rule 4.6.2 states:

> **4.6.2 Same Issue from Multiple Determinations**
>
> Appeals of the same issue from distinct determinations must be pursued in a single appeal. For example, a provider may not appeal an issue from a Medicare contractor's failure to issue a timely Notice of Program Reimbursement ("NPR") and then appeal the same issue from the NPR in separate appeals.

As a result, the Board hereby notifies QRS that, ***within fifteen (15) days of this letter's signature date***, QRS must request a group-to-group transfer of Deaconess Medical Center (Prov. No. 50-0044, FYE 12/31/2005) from Case No. 17-1412G to 17-0554GC. *Be advised that, based on the Group Representative's October 29, 2020 letter inquiring about the status of these EJR requests, this 15-day filing deadline is firm and the Board has determined to exempt it from the Board Alert 19 suspension of Board filing deadlines* Accordingly, if QRS does not timely submit this request (or explain why the Board's mandate is in error), the Board may dismiss Deaconess Medical Center (Prov. No. 50-0044, FYE 12/31/2005) from Case No. 17-1412 pursuant to Board Rule 4.6 and 42 C.F.R. §§ 405.1837(b) and 405.1868.[41]

In the footnote included at the end of this excerpt, the Board stated:

> Dismissal would be appropriate since QRS has already certified that 17-0554GC is complete notwithstanding the duplicate appeal existing in 17-1412G. In this regard, the Board notes that 42 C.F.R. 405.1837(e)(1) states in pertinent part: "The Board will determine that a group appeal brought under paragraph (b)(1) of this section is fully formed upon a notice in writing from the group that it is fully formed. . . . The Board determines that a group appeal brought under paragraph (b)(2) of this section is fully formed upon a notice in writing from the group that it is fully formed, or following an order from the Board that in its judgment, that the group is fully formed, or through general instructions that set forth a schedule for the closing of group appeals brought under paragraph (b)(2) of this section. *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*

[41] (Emphasis in original.)

> *common ownership or control may appeal to the Board the issue that is the subject of the group appeal with respect to a cost reporting period that falls within the calendar year(s) covered by the group appeal*." (Emphasis added.) However, the Board caught QRS' error and, though not required, the Board is allowing a limited period for QRS to cure its error prior to taking action to dismiss Deaconess Medical Center from Case No. 17-1412G.

QRS failed to make that transfer request but rather asserted in its response, dated January 28, 2021, that the Board's mandate was in error based on its contention that the issues in Case Nos. 17-1412G and 17-0554GC were different:

> I am writing in response to the Boards [*sic*] letter of January 21, 2021 asking QRS to respond within 15 days regarding a transfer of Deaconess Medical Center's (50-0044, FYE 12/31/2005) appeal rights contained in Case No. 17-1412G to Case No. 17-0554GC, or to explain why the Board's mandate is in error. I would like to explain why the Board's mandate is in error.
>
> PRRB Rule 13 requires that group appeals must involve a single common question of fact, interpretation of law, regulation or CMS policy or ruling. Case number 17-1412G involve the Disproportionate Share Medicaid Fraction with respect to Dual Eligible patient days (i.e., Medicare Secondary Payer and Exhausted patient days of care).
>
> Case number 17-0554GC, on the other hand, involves the Disproportionate Share SSI/Medicare Fraction with respect to Dual eligible patient days. Deaconess Medical Center appealed each of these issues separately, in accordance with Rule 13, and wishes to pursue both issues. Additionally, appeal rights for Deaconess Medical Center's FYE 12/31/2005 cost reporting period have already been established and are already included in Case No. 17-0554GC. As such, I believe the Board's mandate is in error.

Although the Board had not yet ruled on the proposed dismissal of Deaconess from Case No. 17-1412G (including QRS' January 28, 2021 responsive filing), QRS then refiled on January 11, 2022 the SoP previously submitted in Case No. 17-1412G by letter dated July 17, 2018 (following full formation of the group on May 2, 2018). Significantly, this SoP listed Deaconess FY 2005 as Participant #3 and QRS did not include any information on the Board's proposed dismissal of Deaconess FY 2005 from Case No. 17-1412G or QRS' January 28, 2021 response.

Then, a day later, on January 12, 2022, QRS filed a request for EJR in Case No. 17-1412G and, again, continued to list Deaconess FY 2005 as Participant #3. Contrary to QRS' assertion in its

January 28, 2021 letter that Case No. 17-1412G only pertained to the Medicaid fraction, QRS' EJR request pertained to ***both*** *the Medicare* ***and*** *Medicaid fractions* as demonstrated by the following excerpt from that EJR request which pertained to 80 group cases in the aggregate:

> The specific issue is whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "*dual eligibles*"), and for whom Medicare has not made a payment for that inpatient stay (hereinafter referred to as "*non-covered days*"), should be included in the *Medicare* fraction of the Medicare Disproportionate Share (DSH) adjustment, as alleged by the MAC, or should be excluded from the *Medicare* fraction of the DSH adjustment, and be included in the *Medicaid* fraction, as alleged by the providers.
>
> The Medicare Act states that Medicaid eligible patients who are "*entitled to benefits under [Medicare] Part A*" should be included in the *Medicare* fraction. *Id*. Under the Secretary's regulations promulgated in 2004, Medicare enrollees are considered to be entitled to benefits under Part A even if their inpatient stay is not covered, i.e. paid by Part A. As such, the Secretary's 2004 regulations required that non-covered days be included in the Medicare fraction. However, under the Secretary's pre-2004 regulations, non-covered days were excluded from the Medicare fraction.
>
> Providers assert that the 2004 regulations were improperly promulgated and should therefore be vacated. As a result, the Secretary's policy prior to adoption of these invalidly promulgated regulations of excluding non-covered days from the Medicare fraction should continue in force until such time as the Secretary validly promulgates new regulations. Moreover, if these days are excluded from the Medicare fraction, they must necessarily be included in the Medicaid fraction.[42]

Accordingly, by filing the EJR request in Case No. 17-1412G, QRS effectively changed its position (without any explanation) and now has asserted that Case No. 17-1412G pertains ***not only to*** the Medicaid fraction ***but also to*** the Medicare fraction (indeed, QRS makes the same assertion in the EJR request filed for Case No. 17-0554GC). Accordingly, the participation of Deaconess FY 2005 in Case No. 17-1412G is in ***direct*** *conflict* with its continued participation in Case No. 17-0554GC because, pursuant to 42 C.F.R. § 405.1837(b)(1)(i), commonly owned or controlled providers must pursue a common issue for a particular calendar year as part of a CIRP group and, pursuant to Board Rule 4.6, a provider may not pursue duplicate appeals.

[42] This excerpt (emphasis in original) is from Page 3 of the EJR request filed January 12, 2022 in 80 CIRP groups, where the lead case is Case No. 09-1903G and Case No. 17-1412G is included as one of the 80 group cases covered by that EJR request.

However, the Board may not conduct any further proceedings in Case No. 17-1412G because: (a) QRS filed a complaint for this case in the U.S. District Court for the California Central District based on the ***alleged*** failure of the Board to issue an EJR determination within 30 days of the EJR request (*see* Attachment A); and (b) 42 C.F.R. § 405.1842(h)(3)(iii) specifies that "[i]f 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." As a result of this regulatory prohibition, the Board is foreclosed from exercising its discretion under 42 C.F.R. § 405.1885 to consider (as an alternative to dismissing Deaconess FY 2005 from Case No. 17-1412G) the *potential* remedial action of reopening Case No. 17-1412G to dismiss Deaconess FY 2005 from it.

Accordingly, as an alternative basis for dismissal,[43] the Board dismisses Deaconess 1.0 (for FY 2005) as well as Valley 3.2 (the other remaining Empire Health participant for FY 2005), from Case No. 17-0554GC because Empire Health elected to pursue the merits of its EJR request for FY 2005 as part of the optional group under Case No. 17-1412G. The regulations at 42 C.F.R. § 405.1837(b)(1)(i) and 405.1837(e)(1) prohibit Empire Health from pursuing the same common issue for FY 2005 in another group (which, in this situation, is Case No. 17-0554GC). The history of Case No. 17-1412G, set forth in Attachment A, and the downstream effect of that history on this case, support the Board's actions here.

4. Participant ##2.1 and 4.1 must be dismissed because, in the revised SoP, QRS failed to make a good faith demonstration that it meets the threshold $50,000 AiC requirement

Pursuant to 42 C.F.R. § 405.1837(a)(3), the AiC for a group is determined in accordance with § 405.1839(b), 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 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).[44]

[43] In addition, in Section III(A), the Board dismissed Case No. 17-0554GC in its entirety pursuant to 42 C.F.R. § 405.1868(a)-(b).
[44] (Emphasis added.)

Thus, the AiCs for a group must demonstrate that, if the group's appeal is successful on the group's ***single*** common issue, the change in total program reimbursement for the participants would increase, in the aggregate by more than $50,000. 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 multiple issues, for purposes of meeting the minimum $50,000 AiC threshold, because multiple issues are prohibited within a group appeal request.

As set forth above, the Board has alternative bases to dismiss all the other participants,[45] leaving only Participant ## 2.1 and 4.1. However, based on several independent bases, the Board finds that Participant ## 2.1 and 4.1 failed to meet the AiC threshold requirement.

The final SoP filed on March 3, 2020 lists the AiC for Participant ##2.1 and 4.1 as $95,779 and $7,214 respectively; and it was clearly filed in anticipation of the EJR request filed, days later, on March 13, 2020. The AiC calculation included behind Tab E for both participants is entitled "SSI Fraction – Dual Eligible Days Calculation" and, *without any explanation*, calculates the "total amount to appeal" for each by taking 1 percent of the DSH payment received for the fiscal year at issue. For example, the AIC calculation in its entirety for Participant #2.1 is as follows:

SSI Fraction – Dual Eligible Days Calculation

Provider Name:	Deaconess Medical Center	
Provider No.:	50-0044	
FYI:	12/31/2007	
Disproportionate	Share Calculation Amount:	$9,577,910
		x 1%
	Total amount to appeal:	$95,779

However, the Board finds that QRS did not make good faith AiC calculations to demonstrate it met the minimum $50,000 AiC threshold because the AiC calculations are arbitrary and ambiguous in that *QRS **failed** to provide any explanation for the methodology behind the AiC*

[45] The Board has dismissed the following participants listed in the revised SoP filed on February 22, 2021:
- Participant ##3.1 and 3.3 were improperly added without leave of the Board (Section III(A)(1)) and #3.3 is a improper duplicate of Participant #3.2 (Section III(B)(1)).
- Participant ## 2.0, 3.0, 3.1 and 4.0 were never part of Case No. 17-0554GC as it was a factual impossibility and the representations made by QRS in the SoP were patently false (Section III(A)(2)).
- Pursuant to 42 C.F.R. § 405.1889(b) (as referenced in 42 C.F.R. 405.1835(a)), Participant ##1.0, 2.2 and 4.2 had no right to appeal the revised NPR at issue where the revised NPR was issued for realignment of the Medicare fraction (Section III(B)(2)).
- Participant ##1.0 and 3.2 were dismissed pursuant to 42 C.F.R. § 405.1837(b(1)(i) because Empire Health is already pursuing the common issue for FY 2005 in another group appeal.
- Participant ##5.0-5.4 could never be part of Case No. 17-0554GC as the Board never effectuated the consolidation of 15-3123GC into Case No. 17-0554GC (Section III(A)(1)).

calculations. In particular, it is unclear what the 1 percent represents or what QRS' selection of the 1 percent is based on (particularly since the 1 percent was broadly applied to ***all*** other participants in the group as reflected in the AiC calculation included behind ***each*** participant's Tab E).[46] The Board would expect that the issues, as stated in the EJR, would impact each of these hospitals differently since they would not all have the exact same patient demographics (*e.g.*, they would not have the same percentage of low income patients or dual eligible patients or no-pay Part A days). Moreover, it is unclear whether the 1 percent of the DSH payment represents an impact on the SSI fraction only and, if so, what aspect(s) of the SSI fraction it represents (*e.g.*, the removal of no-pay Part A days included in the denominator of the SSI fraction ***and/or*** the addition of SSI eligible days to the numerator of the SSI fraction). In this regard, the Board notes that a requirement of 42 C.F.R. § 405.1837(c) is that each provider in the group explain "[w]hy the provider believes Medicare payment is incorrect for each disputed item" and "[h]ow and why the provider believes Medicare payment must be determined differently for each disputed item." Thus, the Board finds that QRS has not "demonstrate[d] 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"[47] for ***each*** issue in the EJR request.

Even if the Board were to assume that the AiC calculations were made in good faith, the Board would dismiss the group for having multiple issues and for failing to meet the minimum $50,000 AiC threshold for each issue. As previously stated, 42 C.F.R. § 405.1839(b) restates the mandate in § 405.1837(a) that a group may only contain a single issue for purposes of Board jurisdiction over that group, and that a group may not aggregate issues in order to meet the minimum $50,000 AiC threshold.

In reviewing the Providers' EJR request filed in this case, it appears as if the Providers are appealing *three separate issues*[48] as demonstrated by the following excerpt:

> Quality Reimbursement Services, Inc. ("QRS" or "Provider") as the designated representative for the above referenced group appeal, requests Expedited Judicial Review be granted for the following reasons:
>
> 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

[46] The final SoP filed on March 3, 2020 included at Tab E for each participant an AiC calculation that was simply based on 1 percent of the DSH payment for the relevant fiscal year. This carried over into the revised SoP filed on February 22, 2021 with one exception. A new Participant #3.1 was inappropriately added to the revised SoP (*see supra* note 15 and discussion at Section III(A) wherein the Board dismisses this participant) and the AiC included behind Tab E for the new Participant 3.1 had a different AiC calculation that appears to base that AiC calculation on the reimbursement impact of increasing the SSI percentage from 2.3870 percent to 2.4870 percent.
[47] 42 C.F.R. § 405.1839(a)(1) (emphasis added).
[48] *See infra* note 49.

recognized that it does not have authority to require that noncovered days be excluded from the Medicare fraction and included in the Medicaid fraction and accordingly has granted EJR on this issue.

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** [*sic*] unpaid (i.e., 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 specific issue is whether inpatient hospital days attributable to individuals who are eligible for both Medicare and Medicaid (hereinafter "**dual eligibles"), and for whom Medicare has not made a payment** for that inpatient stay (hereinafter referred to as "non-covered days"), should be included in the Medicare fraction of the Medicare Disproportionate Share (DSH) 2 adjustment, as alleged by the MAC, or **should be excluded from the Medicare fraction of the DSH adjustment, and instead be included in the Medicaid fraction, as alleged by the providers**.

. . . .

Providers assert that the FFY 2005 regulations were improperly promulgated and should therefore be vacated. In fact, these regulations have been vacated (Empire Health Found. v. Price, No. 2:16-CV-209-RMP, 2018 WL 3846315 (E.D. Wash. Aug. 13,2018). As a result, the Secretary's policy prior to adoption of these invalidly promulgated regulations of excluding noncovered days from the Medicare fraction should continue in force until such time as the Secretary validly promulgates new regulations. Moreover, **if these days are excluded from the Medicare fraction, they must necessarily be included in the Medicaid fraction**.

These excerpts suggest that, contrary to the mandate in § 405.1837(a), that a group may only contain one issue, QRS appears to be requesting EJR in Case No. 17-0554GC EJR for 3 separate legal issues,[49] namely:

1. Exclusion of no-pay Part A days from the Medicare fraction based on invalidation of the FY 2005 IPPS Final Rule policy requiring the inclusion of those days in the Medicare fraction.
2. The inclusion of no-pay dual eligible days in the numerator of the Medicaid fraction.[50]
3. The inclusion of eligible SSI days in the numerator of the Medicare fraction (although the reference in the EJR request to this issue is ***fatally*** *flawed* and is not valid).[51]

Thus, the Board does not have jurisdiction over the group since QRS asserts that it contains more than one issue. Further, 42 C.F.R. § 405.1839(b) makes clear that each of these issues (if validly part of the initial group issue statement[52]) would need to meet the $50,000 minimum amount in controversy requirement and that they cannot be aggregated for purposes of meeting that requirement. Because the final SoP with these AiC calculations was submitted concurrent with the EJR request, because QRS failed to give an explanation for the AiC calculations for Participant ##2.1 and 4.1, and because those calculations were made *generically* (and ambiguously) by simply calculating 1 percent of the DSH payment as the alleged AiC, the Board

---

[49] While the EJR request represents that the group appeal contained three issues, *the Board has* ***not*** *made that finding*. Because of the Board's bases for dismissal of this CIRP group in its entirety, *the Board* ***never*** *reached reconciliation of the EJR request to the group appeal request* to determine whether the group appeal request, itself, encompassed all 3 issues raised in the EJR request for purposes of jurisdiction. In this regard, the Board notes that 42 C.F.R. § 405.1837(f)(1) makes clear that "[a]fter 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)." (Emphasis added.)

[50] The Board has a long history of treating appeals seeking the exclusion of no-pay Part A days from the SSI fraction as a separate legal issue from appeals seeking the inclusion of no-pay Part A days involving dual eligibles in the numerator of the Medicaid fraction since the policy in effect prior to the FY 2005 IPPS Final Rule excluded no-pay Part A days from both the Medicare and Medicaid fractions (*see* CMS Ruling 1498-R at 7-6; CMS Ruling 1498-R2 at 3) and the invalidation of the current policy would result in reinstatement to that prior policy (*see Empire Health Found. v. Azar*, 958 F.3d 873 (9th Cir. 2020) ("reinstat[ing] the version of 42 C.F.R. § 412.106(b)(2)(i) which embraced only 'covered' patient days" (*i.e.*, reinstated the rule previously in force), *reversed*, *Becerra v. Empire Health Found.*, No 20-1312, 2022 WL 2276810 (S.Ct. June 24, 2022). Indeed, the Board notes that, in its letter dated January 28, 2021, QRS asserted that the Medicaid fraction was a separate issue in connection with the participation in of Deaconess FY 2005 in both an optional group and this CIRP group for the same year. QRS asserted that the optional group pertained to the Medicaid fraction while this CIRP group pertained to the SSI fraction and, as a result, addressed separate issues.

[51] The Board notes that the EJR request is ***fatally*** *flawed* relative to this issue because it does not meet the content requirements required for an EJR request ***on this issue*** as set forth in Board Rule 42.3 (Aug. 2018) which specifies that 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." (Emphasis added.) 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.

[52] *See supra* note 49.

would have to assume that those calculations would apply equally to all three alleged legal issues.[53] *Based on this assumption*, the aggregate AiC for these 2 participants is $102,993 would be divided by 3 based on the 3 issues alleged in QRS' EJR request. This results in an aggregate AiC of $34,331 for each of the 3 alleged legal issues. As such, the AiC calculation for each of these alleged legal issues would fail to meet the minimum $50,000 threshold for a group and the Board may dismiss the group and Participant ##2.1 and 4.1 as a result of this failure.[54] Indeed, this ambiguity further reinforces the Board's above finding that the AiC calculations are ***not*** a good faith demonstration of the group meeting the minimum $50,000 AiC threshold.[55]

*****

*In summary, pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b), the Board dismisses the **entirety** of Case No. 17-0554GC for: (a) failure of QRS to follow Board Rules relative to SoPs; (b) failure of QRS to comply with the Board's Orders issued on November 30, 2020 and January 18, 2021; and, (c) for **improperly listing participants** on the SoP **based on patently false representations and factual impossibilities***. The Board, in Section III(B), sets forth multiple alternative bases for the dismissal of Case No. 17-0554GC. The Board further denies EJR both based on the dismissal and the lack of jurisdiction (as demonstrated by the alternative bases for dismissal).[56] Due to the nature of the Board's remedial action, the Board has carbon copied Empire Health on this determination.

Board Members Participating:

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

For the Board:

7/12/2022

X Clayton J. Nix

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

Enclosure – Attachment A – Copy of Board Letter Dated 6/10/2022

Cc: David Luhn, CFO, Empire Health Foundation
Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, Federal Specialized Services

[53] This is reinforced by the fact that QRS used a different methodology for calculating the AiC for the founding provider and then switched it to this new 1-percent methodology as reflected in the final SoP and revised SoP behind Tab 3.0E. Presumably, QRS switched methodologies in the final SoP filed on March 3, 2020 in order to more accurately reflect the AiC in anticipation of the EJR request being filed days later on March 13, 2020. *See* 42 C.F.R. § 405.1839(c)(5).
[54] *See* 42 C.F.R. §§ 405.1837(e)(2); 405.1839(b). *See also infra* note 55.
[55] The Board further notes that, because there is no good faith demonstration of the AiC for any of the participants in Case No. 17-0554GC, the AiC calculations are fatally flawed and have no value. As such, the Board has no basis to bifurcate Participant ##2.1 or 4.1 pursuant to 42 C.F.R. 405.1837(f)(2) because there is no good faith demonstration that either of those participants would meet the minimum $10,000 AiC threshold.
[56] *See supra* note 51 discussing how the EJR request is ***fatally*** *flawed.*

ATTACHMENT A

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

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James Ravindran
Quality Reimbursement Services, Inc.
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RE: ***Deferring Show Cause Order & Closure of Cases***
Case No. 09-1903GC, *et al.* (*see* attached list of 80 group cases[1])

Dear Mr. Berends and Ravindran:

As the parties are aware, Quality Reimbursement Services, Inc. ("QRS"), the Providers' designated representative, filed a consolidated request for expedited judicial review ("EJR") on January 12, 2022 for the above-referenced 80 group cases involving, in the aggregate, over 950 participants.[2] On January 20, 2022, the Medicare Contractors' representative, Federal Specialized Services ("FSS"), requested an extension of time to review these 80 cases for jurisdictional issues due to the sheer size of these groups, the number of Medicare contractors involved and pending unresolved jurisdictional challenges filed in at least 8 of the group cases.[3] Shortly thereafter, on January 24, 2022, the Board issued a Notice of Stay and Scheduling Order ("Scheduling Order") to manage the jurisdictional review process for these 80 group cases and 950+ participants, assigning ongoing tasks to both parties and making known the Board's position that the 30-day period for responding to an EJR request does not begin until the Board finds jurisdiction pursuant to 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. § 405.1842(b)(2). *Following the Board's Scheduling Order, the Providers were* ***silent*** *and* filed ***no objections*** *or requests for clarification with regard to the Scheduling Order*. On February 14, 2022, without notice to the Board or the opposing parties in these cases, QRS bypassed the ongoing jurisdictional review process by filing a lawsuit in the U.S.

[1] The Board has excluded Case No. 20-0162GC entitled "Hartford Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group" from the instant Scheduling Order because it was adjudicated by the Board and closed on March 17, 2022, several weeks prior to QRS' April 8, 2022 letter. Further, the Board added the optional group under Case No. 19-2515G entitled "QRS CY 2016 DSH Medicaid Fraction Dual Eligible Days Group" which was included in the EJR Request filed on February 16, 2022 that is identical to the one filed on January 20, 2022. *See* Board letter (Jan. 24, 2022) at n.26, n.27 for a more detailed explanation.

[2] *See supra* note 1.

[3] FSS' Response to Providers' Request for EJR (Jan. 20, 2022) identified the jurisdictional challenges as being pending and unresolved in the following 8 group cases:

- Case No. 18-1738GC (JC filed 10/14/21) because the providers improperly expanded the appeal request;
- Case No. 19-0014GC (JC filed 3/8/21) because several providers failed to include the group issue in their hearing request, failed to timely add the issue to their individual appeals and failed to properly transfer into the group and because the group providers improperly expanded their appeal request.
- Case No. 19-0164GC (filed 11/10/21) because: (1) the providers transferred the same issue to another group (Case No. 18-0037GC); and (2) the DSH – Medicaid Fraction/Dual Eligible Days issue was improperly/untimely added.
- Additional jurisdictional challenges have been filed in Case Nos. 14-1171G (filed 8/6/15), 14-1818G (filed 9/14/15), 14-3306G (filed 12/28/15), 14-3308G (filed 12/28/15) and 20-0244G (filed 6/24/21).

District Court for the Central District of California ("California Central District Court") seeking judicial review on the merits of its consolidated EJR request in these 80 cases. On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed the requisite responses. On April 8, 2022, ***roughly 2½ months after the Board's January 24, 2022 Scheduling Order***, QRS broke its silence and informed the Board and the Medicare Contractors of this lawsuit by filing the "Providers *Response* to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903, et at [*sic*]"[4] ("Providers' Response"). In its entirety, Providers' Response stated:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

On April 18, 2022, FSS filed a request for dismissal of the Providers' cases for failure to comply with the Board's Scheduling Orders ("Request for Dismissal"). On April 24, 2022, the Board issued to the Providers an Order to Show Cause Why Dismissal Is Not Warranted ("Order to Show Cause") and the parties filed responses thereto.

As set forth in more detail below, the Board hereby takes the following actions:

1. Closes these 80 cases consistent with 42 C.F.R. § 405.1842(h)(3)(iii); and
2. Defers action on its Order to Show Cause, based on QRS' numerous, egregious, regulatory violations, until such time as there is an Administrator's Remand Order consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure ("FRCP") 62.1.[5]

Procedural Background

On January 12, 2022, QRS filed an EJR for the above 80 group cases.[6] *In the majority of these group cases*, QRS filed an electronic copy of the Schedule of Providers ("SoP"), with supporting

[4] (Emphasis added.)
[5] FRCP 62.1 is entitled "Indicative Ruling on a Motion for Relief That is Barred by a Pending Appeal." While FRCP 62.1 is not directly applicable to the Board, the procedural developments in these cases are similar those addressed in FRCP 62.1 and the Board looked to it for guidance,
[6] *See supra* note 1.

documentation, one or two days prior to the EJR request.[7] Per Board Rule 20.1.1 (Nov. 1, 2021), the SoP must "demonstrate[] that the Board has jurisdiction over ***each*** participant named in the group appeal."[8] Significantly, the overwhelming majority of these cases are *optional* groups and roughly 90 percent of the over 950 participants are in those *optional* groups. As explained at Board Rule 12.3.2 (Nov. 1, 2021), "[p]roviders not under common ownership or control may choose to join together to file an ***optional*** group appeal for a specific matter that is common to the providers for any fiscal year that ends in the same calendar year, but they are not required to do so."[9] In contrast, Board Rule 12.3.1 explains when a mandatory common issue related party ("CIRP") group appeal is required, "[p]roviders under common ownership or control that wish to appeal a specific matter that is common to the providers for fiscal years that end in the same calendar year ***must*** bring the appeal as a group appeal. See 42 C.F.R. § 405.1837(b)."[10]

On January 20, 2022, FSS requested a 60-day extension of time to review these 80 cases for jurisdictional issues "due to the sheer size of the groups, the recent closure of several of the groups and the number of [Medicare Contractors] involved."[11] FSS also noted that there were pending jurisdictional challenges in 8 of the 80 cases.[12] Finally, FSS noted that jurisdiction is paramount and maintained that its request was consistent with the intent of Board Rules 44.6 and 22 which give Medicare Contractors 60 days to review the final SoP (including the underlying jurisdictional documentation for each participant) and file jurisdictional challenges, as relevant, following receipt of the final SoP.

The January 24, 2022, Scheduling Order explained that, on March 25, 2020, the Board issued Alert 19 to notify affected parties of "Temporary COVID-19 Adjustments to PRRB Processes." In Alert 19, the Board explained that the Board and CMS support staff temporarily adjusted their operations by maximizing telework for the near future.[13] The Scheduling Order further explained that, as the result of the surge in the Omicron variant of the COVID-19 virus, the skeletal Board staff that had returned to the office on a part-time basis, had resumed telework status.[14] While Alert 19 explained that, whenever possible, the Board planned to continue processing EJR requests within 30 days, the Board emphasized that it must have access to the jurisdictional documents to review and issue an EJR decisions. Accordingly, the Scheduling Order notified the parties in this case that it had stayed the 30-day period for responding to the EJR request for the above-captioned group appeals as follows:

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[7] It appears that, in these situations, QRS was refiling an SoP previously filed.
[8] (Emphasis added.)
[9] (Emphasis added.)
[10] (Emphasis added.) Board Rule 12.3.2 is based on directive in 42 U.S.C. 1395oo(f)(1) and 42 C.F.R. 405.1837(b)(1)(i). In particular, this regulations states: "Two or more providers that are under common ownership or control that wish to appeal to the Board a specific matter at issue that involves a question of fact or interpretation of law, regulations, or CMS Rulings that is common to the providers, and that arises in cost reporting periods that end in the same calendar year, and for which the amount in controversy is $50,000 or more in the aggregate, must bring the appeal as a group appeal."
[11] FSS' Response to Providers' Request for EJR (Jan. 20, 2022).
[12] *See supra* note 3.
[13] On January 14, 2022, the Secretary renewed the order finding that public health emergency exists as a result of COVID 19. *See* https://www.phe.gov/emergency/news/healthactions/phe/Pages/default.aspx.
[14] *See also infra* note 62.

> As you are aware, Board Rules require that Schedules of Providers ("SOPs") be filed in hard copy when, as is here, the group appeal has not been fully populated in OH CDMS. As the Board does not have access to the hard copy Schedules of Providers filed in the attached list of cases (regardless of whether they were filed shortly before the EJR, after the EJR, or at some point in the past), the Board is not able to process them in the usual manner and establish jurisdiction, *i.e.*, **whether "a provider of services may obtain a hearing under" the Board's governing statute, which is a necessary jurisdictional prerequisite for a case to eligible for EJR. 42 U.S.C. § 1395oo(f); *see also* 42 C.F.R. § 405.1842(b)**. Accordingly, the Board: (1) will follow the standards set forth in the CMS regulations at 42 C.F.R. § 405.1801(d)(2) when calculating the Board's 30-day time period by excluding all days where the Board is not able to conduct its business in the usual manner; and (2) has stayed the 30-day period for responding to the EJR request for the above-captioned group appeals.[15]

In addition, the Scheduling Order set deadlines for each party to file and/or respond to any jurisdictional issues identified, and to upload any additional, relevant, documents or briefs to their respective cases in OH CDMS, to the extent that they were not already populated therein. Further, the Board requested that the record in these cases be supplemented with certain germane information from the individual appeals, from which participants had been transferred, to ensure the record before the Board was complete for purposes of the Board's jurisdictional review.[16] Finally, the Board noted that, per 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), and (e)(3)(ii), "jurisdiction is a prerequisite to consideration of an EJR request" and "this Scheduling Order necessarily affects the 30-day period for responding to the EJR request." In the footnote appended to this statement, the Board further explained that "A Board finding of jurisdiction is a ***prerequisite*** to any review of an EJR request pursuant to 42 C.F.R. § 405.1842 and the Board has the authority to request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision[]" [i]ncluding documentation relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (referencing to the decision in subsection (f) which includes a decision on both jurisdiction and the EJR request)."[17]

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[15] (Footnote omitted and bold and underline emphasis added.)

[16] Specifically, the Board stated: "The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case* ***so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases***." Board letter (Jan. 24, 2022) (emphasis added).

[17] (Emphasis in original.)

Under Board Rule 44.3, if a party intends to respond to a motion, it must do so within 30 days, unless the Board imposes a different deadline. Significantly, QRS did not file any objection to FSS' request for an extension prior to the Rule 44.3 30-day time deadline. Nor did QRS file any objection to the Scheduling Order. QRS was simply silent.

On March 14, 2022, FSS complied with the Board's Scheduling Order and timely filed jurisdictional challenges in 15 distinct group cases. These challenges were different from, and in addition to, the 8 pending, unresolved, jurisdictional challenges that FSS noted in its initial January 20, 2022 response.[18]

On April 8, 2022, roughly 2½ months after the Board issued its Scheduling Order, QRS broke its silence to file the 4-sentence Providers Response[19] which, in whole, reads:

> In response to the Board letter dated January 24, 2022 in which the Board requested certain follow up action on the part of the Providers, the Providers respectfully note that they have filed a Federal complaint in the Central District of California based on the failure of the PRRB to render its EJR decision within 30 days. As such, the Providers consider that proceedings before the PRRB have been exhausted. Accordingly, the PRRB's previously established due dates no longer apply to the Providers.
>
> Should you have any questions, please contact the undersigned at [telephone number].

Providers' Response makes clear that the Providers are abandoning the Board's jurisdictional review process and are not complying with the Board's January 24, 2022 Scheduling Order by stating: "*the Providers consider that proceedings before the PRRB have been* ***exhausted*** [and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[20]

On April 18, 2022, FSS filed its Request for Dismissal wherein it requested the Board either: (1) dismiss these 80 cases for "failure to comply with Board rules and deadlines [in the January 24, 2022 Scheduling Order] and for, in essence, abandoning the issues before the Board" by filing a complaint in federal district court; or (2) "[i]n the alternative, . . . dismiss each of the cases for which the MACs have filed jurisdictional or substantive claim challenges."

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[18] *See supra* note 3.

[19] Again, the Board notes that the caption for April 8, 2022 filing clearly notes it was intended as a response to the Board's Notice of Stay and Scheduling Order: "Providers Response to PRRB's January 24, 2022 Ruling on FSS' Extension Request Relating to QRS' Combined EJR Request with respect to 80 Groups Case Nos. 09-1903GC, et at (See Attached list)"

[20] Board Scheduling Order n.23 (Apr 21, 2022) (emphasis added).

In response to these filings, the Board issued an Order to Show Cause, on April 21, 2022, directing QRS to respond, no later than May 5, 2022, to FSS' Request for Dismissal and to Show Cause why the Board should not dismiss these 80 cases in their entirety based on:

- The Providers' failure to timely respond to the Medicare Contractor's Extension Request or the ensuing January 24, 2022 Board Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- The Providers' abandonment of the Board's ongoing jurisdictional review process and refusal to comply with the Board's Scheduling Order for the management of that review process.

On May 5, 2022, QRS filed a response on behalf of the Providers urging the Board to not dismiss the cases because, "although it is the desire of the Providers to cooperate with the Board and the MAC, the Providers explain the basis for their commencement of an action in federal court, which the Providers continue to believe is legally appropriate, and why the Board should not dismiss these cases." QRS explains that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that they "notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court." QRS contends that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that *the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases*." In taking this position, the Providers readily recognize that they "are aware that there are other extenuating circumstances, such as COVID related staffing issues, which are hampering the Board's ability to process EJR requests."[21] However, "[w]hile sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met." Finally, QRS asserts that "although the Providers have commenced an action in federal court, since the Board appears to believe that it retains authority over these cases, the Providers respond to the jurisdictional issues that Federal Specialized Services ("FSS") has raised."

Given the nature of QRS' response, and the arguments presented therein, the Board issued a Scheduling Order on May 6, 2022, directing that any response by FSS to QRS's filing must be filed no later than May 12, 2022. Accordingly, FSS responded on May 9, 2022 contending that:

1. The Providers' contention in its May 5, 2022 filing that the Board lacked the authority to allow the Medicare Contractors additional time to review and raise jurisdictional challenges was not timely and properly raised.

2. The Providers improperly waited nearly 2 months to advise the Board that such a complaint had been filed. The Providers' contention that CMS was responsible for advising the Board of a complaint's filing is countered by the fact that "there is no record that the summons was

[21] QRS letter dated May 5, 2022 filed in Case No. 09-1903GC, *et al*.

served" and that service did not occur until two months later on April 12, 2022 when an alias summons was issued in the case. Further, "when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed.

3. The Providers failed to timely respond to any of the jurisdictional challenges raised by the Medicare Contractors.

4. After a lawsuit is filed, 42 C.F.R. § 405.1842(h)(3)(iii) does not prohibit further Board action to determine jurisdiction.[22]

Board Findings and Ruling:

The Board must decide what effect the Providers' filing of a lawsuit has on the proceedings before the Board in connection with the above-referenced 80 cases.

A. The 30-day Period For Responding to the Consolidated EJR Request Has Not Yet Begun and Bypassing the Completion of that Process Raises Fraud, Waste and Abuse Issues.

Parties to a Board appeal may request EJR pursuant to the provisions of 42 U.S.C. § 1395oo(f)(1) which states, in relevant part:

> Providers shall also have the right to obtain judicial review of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question, by a civil action commenced within sixty days of the date on which notification of such determination is received. ***If a provider of services may obtain a hearing under subsection (a)*** and has filed a request for such a hearing, such provider may file a request for a determination by the Board of its authority to decide the question of law or regulations relevant to the matters in controversy (accompanied by such documents and materials as the Board shall require for purposes of rendering such determination). *The Board shall render such determination in writing within thirty days* ***after the Board receives the request and such accompanying documents and materials***, and the determination shall be considered a final decision and not subject to review by the Secretary.[23]

[22] 42 C.F.R. § 405.1842(h)(3)(iii) states, "If the lawsuit is filed before a final EJR decision is issued on the legal question, the Board may not conduct any further proceedings on the legal question or the matter at issue until the lawsuit is resolved."
[23] (Emphasis added).

To implement this statutory provision, the Secretary promulgated the regulation at 42 C.F.R. § 405.1842, setting forth the process for obtaining EJR, and the Board's obligations under the statute. As demonstrated by the following excerpts, 42 C.F.R. § 405.1842 makes clear that the 30-day clock for processing an EJR request does not begin until ***after*** the Board rules on jurisdiction:

> (a) *Basis and scope*. (1) This section implements provisions in section 1878(f)(1) of the Act that give **a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter** (as described in § 405.1840 of this subpart), and the Board determines it lacks the authority to decide the legal question (as described in § 405.1867 of this subpart, which explains the scope of the Board's legal authority).
>
> (2) A provider may request a Board decision that the provider is entitled to seek EJR or the Board may consider issuing a decision on its own motion. **Each EJR decision by the Board must include a specific jurisdictional finding on the matter(s) at issue**, and, where the Board determines that it does have jurisdiction on the matter(s) at issue, a separate determination of the Board's authority to decide the legal question(s).
>
> ****
>
> (4) **The provider has a right to seek EJR** of the legal question under section 1878(f)(1) of the Act ***only if***—
>
> (i) **The final EJR decision of the Board or the Administrator, as applicable, includes a finding of Board jurisdiction over the specific matter at issue a**nd a determination by the Board that it has no authority to decide the relevant legal question; or
>
> (ii) The Board fails to make a determination of its authority to decide the legal **question no later than 30 days after finding jurisdiction over the matter at issue and notifying the provider that the provider's EJR request is complete**.
>
> (b) *General*—(1) *Prerequisite of Board jurisdiction*. The Board (or the Administrator) **must find that the Board has jurisdiction over the specific matter at issue before the Board may determine its authority to decide the legal question**.

> (2) *Initiating EJR procedures*. A provider or group of providers may request the Board to grant EJR of a specific matter or matters under appeal . . . . Under paragraphs (d) and (e) of this section, **a provider may request** a determination of the Board's authority to decide a legal question, but **the 30-day period for the Board to make a determination under section 1878(f)(1) of the Act** [*i.e.*, 42 U.S.C. § 1395oo(f)(1)] **does not begin to run until the Board finds jurisdiction to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete**.[24]

Clearly, when implementing 42 U.S.C. § 1395oo(f)(1) through 42 C.F.R. § 405.1842, the Secretary recognized that the 30-day period "does not begin to run ***until the Board finds jurisdiction*** to conduct a hearing on the specific matter at issue in the EJR request and notifies the provider that the provider's request is complete."[25] Moreover, the Board is bound by this regulation because, as stated in 42 C.F.R. § 405.1867, "[i]n exercising its authority to conduct proceedings under this subpart, *the Board must comply with all* the provisions of Title XVIII of the Act *and* ***regulations issued thereunder*** . . . ." Consistent with this regulation, Board Rule 42.1 states, in pertinent part:

> Board jurisdiction must be established *prior to* granting an EJR request. Similarly, the Board must process and rule on any substantive claim challenges pertaining to the cost report at issue *prior to* granting an EJR request (see Rule 44.5). . . . The Board will make an EJR determination within 30 days ***after*** it determines whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[26]

Thus, it is clear that the 30-day clock does not start until ***after*** the Board determines that it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers participate) underlying an EJR request. Note that the Board's use of the term "stay" (as used in this

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[24] (Emphasis added).
[25] 42 C.F.R. § 405.1842(b)(2) (emphasis added). *See also* 69 Fed. Reg. 35716, 35730 (June 25, 2004) (proposed rule explaining: "In proposed § 405.1842(b), we would set forth an overview of the EJR process. We believe that an overview would be helpful given the complexity of the process. In § 405.1842(b)(l), ***we would emphasize that a Board finding that it has jurisdiction*** *over the specific matter at issue* ***is a prerequisite*** *for its determination of its authority to decide the legal question*, and for the ensuing stages of the EJR process. Section 1878(f)(1) of the Act states that a provider may file a request for EJR '[i]f [such] provider of services may obtain a hearing under subsection (a) [which sets forth the jurisdictional requirements for obtaining a Board hearing].' In § 405.1842(b)(2) we would state that the EJR procedures may be initiated in two ways. First, a provider or group of providers may request the Board to grant EJR, or, second, the Board may consider on its own motion whether to grant EJR. We would also state in paragraph (b)(2), ***consistent with*** *the requirement that a Board finding of jurisdiction is a prerequisite of both the provider's ability to obtain EJR and the Board's authority to issue an EJR Decision*, that ***the 30-day time limit*** specified in section 1878(f)(l) of the Act for the Board to act on a provider's complete request ***does not begin to run until the Board has found jurisdiction*** on the specific matter at issue." (emphasis added)).
[26] (Emphasis added.)

and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.

The Board notes that the Secretary had a sound basis for issuing 42 C.F.R. § 405.1842(b)(2). The statute itself states that a provider may be authorized to request EJR "***if*** [it] ***may obtain a hearing under subsection (a). . . .***"[27] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*") noted, "the statute itself suggests that an EJR request need not be considered before the Board determines it has jurisdiction over an appeal. Moreover, the legislative history makes clear that in enacting the EJR provision, Congress sought solely to expedite resolution of the *legal* controversies in Medicare reimbursement appeals."[28] The Court in *Alexandria* continued, stating:

> Nor will the hospitals be heard to argue that the filing of an EJR request requires the PRRB to determine its jurisdiction over an appeal *and* respond to the EJR request within 30 days. Such an argument confuses what are in reality two separate analyses: jurisdiction and EJR. *The jurisdictional analysis determines whether the PRRB may consider a provider's appeal*. The EJR inquiry, on the other hand, determines whether a party properly before the PRRB raises issues which must be resolved before a court rather than the Board. *The language of the statute supports this distinction.* EJR requests relate to the authority of the PRRB to decide questions of law, not whether an appeal is properly before them. While Congress has clearly imposed a 30-day limit on the PRRB's evaluation of EJR requests, no such limits have been placed on the PRRB's evaluation of its jurisdiction. . . .
>
> The court is also unconvinced that Congress meant to require evaluation of EJR requests within a 30-day time frame when the PRRB has not made a jurisdictional determination. It makes no sense to require the PRRB to evaluate an EJR request they might never reach if the appeal is not properly before the Board. *Thus, the hospitals' argument that the PRRB absolutely must make an EJR determination within 30 days of document receipt is* ***without merit***.[29]

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[27] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[28] *See* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986); *San Francisco General Hosp. v. Shalala,* No. C 98-00916, 1999 WL 717830 (N.D. Cal. Sept. 8, 1999); *Total Care, Inc. v. Sullivan,* 754 F. Supp. 1097 (W.D. N.C. 1991); *Abington Mem'l Hosp. v. Bowen,* Civ. A No. 86-7262, 1988 WL 71367 (E.D. Pa. July 1, 1988); *Good Samaritan Hosp. v. Heckler*, No. CV84-L-459, 1986 WL 68497 (D. Neb. June 27, 1986).
[29] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.

The *Alexandria* Court's conclusions are also supported by the practical considerations involved in the EJR process. If EJR requests were permitted to supersede jurisdictional determinations, there would be only two logical outcomes. The first is that jurisdictional determinations need never be made in cases where EJR requests are filed before a jurisdictional determination is reached by the Board. This would result in fraud, waste and abuse concerns if parties, unable to meet the Board's jurisdictional requirements, would still able to prevail in federal court, merely by filing an EJR request. The second conclusion is that federal trial courts would be forced to resolve jurisdictional disputes.[30] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

Significantly, in these 80 group cases, with over 950 participants, the Board has not yet completed its jurisdictional review to confirm whether it has jurisdiction to hear all of the providers' disputes raised in the EJR request. Having sufficient time to complete the jurisdictional and substantive claim review[31] process is important to ensure that the groups, and all of the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR request. Further, the jurisdictional and substantive claim review process ensures that the groups, and underlying providers, have complied with the applicable Board regulations and rules (*e.g.*, have not previously withdrawn or been dismissed without being reinstated; are not pursuing a prohibited duplicate appeal of the same issue for the same year; and have complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise. Indeed, these concerns are very real and evident in these 80 group cases.

In compliance with the Board's January 24, 2022 Scheduling Order, the Medicare Contractors began submitting Jurisdictional Challenges in their respective cases. On March 14, 2022, FSS timely filed a comprehensive response noting that Jurisdictional Challenges and/or Substantive Claim Challenges had been filed in 15 of the 80 group cases encompassed in the instant EJR request. These challenges as well as separate challenges or jurisdictional issued raised by the Medicare Contractors directly (both prior to and after the consolidated EJR request was filed) include, but are not limited to:

- Jurisdictional challenges claiming that, pursuant to 42 C.F.R. § 405.1889(b), certain providers had no right to appeal a revised NPR for the group issue. Cases affected include Case Nos. 13-3191GC, 13-1440G, 13-2678G, 13-2693G; 14-1174G; 15-1067G; 15-2385G, 20-0250G, 20-0244G.

- Jurisdictional challenges identifying certain participants may not have been validly transferred from an individual appeal into the relevant group because the issue that the participant sought to transfer was not properly part of the individual appeal (*i.e.*, was

[30] It is hard to see federal courts deciding jurisdictional issues, including determining whether a case or provider: (a) has been previously withdrawn or dismissed without being reinstated; (b) is pursuing a prohibited duplicate appeal of the same issue for the same year; or (c) has complied with the mandatory CIRP group rules.
[31] As stated in Board Rule 44.5, "[t]he Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

neither properly part of the appeal request nor properly added pursuant to 42 C.F.R. §§ 405.1835(a)-(b), (e)). In some situations, the Medicare Contractor has suggested that the transferred issue is narrower than the group issue and, as such, that there has been an improper attempt to expand the issue from the individual appeal. Cases affected include Case No. 13-3191GC, 13-2678G, 15-2385G, 18-1738G, 19-0014GC, 19-0164GC.

- Jurisdictional challenges arguing that certain providers should be dismissed because they were already a participant for the same issue and year in another appeal. Cases affected include Case Nos. 15-0018G, 15-3031G, 15-3039G and 19-0164GC.

- Jurisdictional challenge claiming that certain providers should be dismissed because they appealed prematurely under 42 C.F.R. § 405.1835(c) for failure to timely issue a determination. Cases affected include 15-0018G and 15-1419G.

- A jurisdictional challenge that Case No. 15-1067G is not valid because the group failed to meet the minimum $50,000 amount in controversy as documented in the SoP and supporting documents filed for this group.

- A jurisdictional challenge in Case No. 15-2385G alleging that there is no documentation establishing that a provider was properly transferred into the group.

- Jurisdictional challenges identifying multiple providers that were ***improperly*** listed in the SoP after they were ***previously*** withdrawn by QRS, dismissed by the Board or its transfer to the group was denied. Cases affected include Case Nos. 13-2678G, 13-2693G, 13-1440G, 14-1174G, 15-1419G, 15-3031GC, and 15-3039G.[32]

- Jurisdictional challenges claiming that, because certain providers are commonly owned or controlled, they could be required to be part of a mandatory CIRP group. Accordingly, they may not be a participant in the relevant optional group and could be subject to dismissal. Cases affected include Case Nos. 15-1419G, 15-3031G, 18-1259G, 18-1260G.[33]

- Jurisdictional challenges raising questions whether QRS was an authorized representative of certain participants. Cases affected include Case Nos. 13-2678G, 13-2693G, 15-2385G.

- Jurisdictional challenges in Case No. 16-1142G, 18-1259G, and 18-1260G averring that the determination at issue for a participant was not included as required by 42 C.F.R. § 405.1835(b) and should be reviewed for dismissal.

[32] Most of the challenges for the withdrawn/dismissed participants are raised through exhibits attached to the jurisdictional challenges showing correspondence either from QRS withdrawing the participant or from the Board dismissing the participant and/or denying transfer to the relevant group.

[33] In one situation, the Medicare Contractor has identified a CIRP group for the same issue and year in which it believes the provider is a participant and, if so, that duplication would be a clear violation of the mandatory CIRP regulation and Board Rule 4.6 prohibiting duplicate appeals. In another, the Medicare Contractor identified 2 CIRP providers participating in the same *optional* group with an aggregate amount in controversy in excess of $50,000, which if true would violate the mandatory CIRP regulation.

- Jurisdictional issues noted in Cases No. 20-0248, 20-0250G, and 20-0411GC regarding certain providers that failed to properly establish an individual appeal prior to transferring to the group because they failed to *timely* file their individual appeal within the period allowed by 42 C.F.R. § 405.1835(a)(3).

- Jurisdictional challenges filed in Case Nos. 14-1818G, 14-3306G, 14-3308G allege that certain providers did not include a claim for the item on their cost report and did not identify the item as a self-disallowed cost by identifying the issue as a protested amount on their cost report.

- A substantive claim challenge[34] was filed for Case No. 19-2513 claiming that none of the providers included an appropriate claim for the appealed item in dispute as required under 42 C.F.R. § 413.24(j).

In addition, the Board through its ongoing review of jurisdiction, and other procedural issues, in these 80 group cases, has identified ***numerous, material,*** jurisdictional issues and concerns that were not raised by FSS or the Medicare Contractors. The issues and concerns identified by the Board include, but are not limited to, the following.

1. *Prohibited Duplicate Appeals*

   There are violations of Board Rule 4.6 prohibiting duplicate appeals. For example, the participants in Case No. 09-1903GC (BHCS 07 DSH Dual Eligible Days) are duplicative of the participants, and the cost reporting periods, at issue in Case Nos. 13-3896GC and 13-3938GC.

2. *Providers With No Appeal Rights*

   There are additional providers that, pursuant to 42 C.F.R. §405.1889(b), had no right to appeal a revised NPR for the group issue. Other examples outside of those identified by the Medicare Contractors include Case Nos. 20-0248G and 20-0250G.

3. *Improper Pursuit of Previously Withdrawn/Dismissed Participants in Excess of $1 million*

   There are a significant number of participants in these 80 groups for whom QRS is ***improperly*** pursuing reimbursement by including them on the Schedule of Providers even though they were either ***previously withdrawn by QRS*** from the relevant group case, the Board denied the transfer to the group appeal ***or*** the Board dismissed them. Although the Board has not completed its review, the following examples from only 8 of the 80 cases alone demonstrate that QRS is ***improperly*** pursuing reimbursement ***in excess of $1 million.***

[34] *See supra* note 31 (discussing what the Board's use of the term "substantive claim challenge" means).

Such action on the part of QRS raises significant fraud and abuse concerns,[35] and the Board takes administrative notice that this is not an isolated concern. Fraud and abuse concerns naturally arise in instances where a provider (or a provider representative) fails to follow Board Rules and the Board's governing regulations[36] by: (a) pursuing prohibited duplicate reimbursement claims for the same issue and year in multiple cases; or (b) pursuing reimbursement for issues that were previously formally withdrawn, or dismissed, and have not been reinstated by the Board. *To this end, a group representative has a responsibility to track and manage its cases and ensure due diligence is exercised* ***prior to*** *making filings.* Recent examples of group cases in which the Board has identified that QRS has improperly included previously dismissed or withdrawn providers on final SoPs without identifying those prior dismissals/withdrawals; ***or*** prior group cases in which withdrawals were ***required*** under settlement with the government but were not withdrawn, even after notification was sent to QRS separately by the relevant Medicare contractor or FSS

[35] Based on its preliminary review of just some of these cases, the Board fully expects to identify a significant number of other situations where QRS failed to remove withdrawn/dismissed providers from the SoPs, particularly in light of the age of the SoPs that QRS refiled and is relying on for its consolidated EJR request (*e.g.*, relying on 9+ year old SoPs in Case Nos. 13-3942G and 13-3944G where there are 106 participants in the aggregate). Indeed, the Medicare Contractors have already identified some of these other situations. *See supra* note 32 and accompanying text. Further, in its May 5, 2022 response to the Board's Show Cause Order, QRS sets forth in Exhibit 4 a listing of the 14 previously withdrawn/dismissed providers that the Medicare Contractors had identified *with an AIC in the aggregate of $1,054,115.* Seven of these 14 (with an aggregate AiC of $476,115) overlap with the Board's preliminary listing, *infra*, of previously withdrawn/dismissed providers:

- Case No. 13-2678G – #22 Leesburg RMC and #27 Union General Hospital; and
- Case No. 13-2693G – #26 Wuesthoff MC;
- Case No. 14-1174GC – #19 Shands Jacksonville Medical Center, #23 Leesburg Regional Medical Center, #28 Union General Hospital, and #39 MedCenter One Inc.

The ones not on the Board's list have an aggregate AiC of $578,000 and include:

- Case No. 13-2678G – #38 St. Alexius MC and #39 Bismarck MedCenter One;
- Case No. 15-0018GC – #4 Cox Medical Center;
- Case No. 15-1419G – #1 Lawrence & Memorial Hospital on SoP-A and #21 FF Thompson Hospital on SoP-B;
- Case No. 15-3031G – #26 Wilkes Regional MC; and
- Case No. 15-3039G – #25 Wilkes Regional MC.

Accordingly, the AiC of Board's preliminary listing of previously withdrawn/dismissed participants would increase from $1,038,115 to ***$1,616,115*** if these additional 7 are included. The Board is confident that it would identify additional instances if it were to complete its jurisdictional review process (*e.g.*, the Medicare Contractors identified Case Nos 13-1440G (C-4) and 14-1171G as having previously withdrawn/dismissed providers but those cases are ***not*** on QRS' list of 14). The Board listing, plus the Medicare Contractors listing, demonstrates the hollowness of QRS' offer to simply withdraw the 14 Providers the Medicare Contractors identified (roughly 30% of what has thus far been identified this issue). This is more than a mere oversight, as QRS clearly failed to exercise any, much less due, diligence, when it resubmitted stale SoPs concurrent with the consolidated EJR request.

[36] *See, e.g.*, 42 U.S.C. § 3729 (False Claims Act).

include: Case Nos. 10-0924GC,[37] 12-0281G,[38] 13-3075,[39] 13-3928G, 13-3941G,[40] 14-4385GC, 14-4386GC,[41] 14-4171GC, 14-4172GC,[42] 15-0020G, 15-1423G,[43] 15-0585GC, 15-0587GC,[44] 15-3484GC,[45] 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, 16-1349GC,[46] 17-0568GC, and 19-2376GC. [47] These examples highlight, *at a minimum*, QRS' reckless disregard for its

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[37] As part of an EJR determination dated August 2, 2019, the Board notified QRS that it had *improperly* included Participant #1 on the SoP because it had filed a void transfer request to transfer from a case which the Board had closed more than 3 years earlier -- Case No. 08-1716.

[38] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly"* included Participant #9 on the SoP because the Board previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeal.

[39] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly"* included a Provider on the SoP for Case No. 13-3075GC because, on October 24, 201**3**, the Board had previously denied the request to transfer because the Provider did not timely appeal the issue for which transfer was requested.

[40] As part of an EJR determination dated April 8, 2019, the Board notified QRS that it had "*improperly"* included Rapid City Regional Hospital as a participant in the SoPs for Case Nos 13-3928G and 13-3941G because the Board previously had issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[41] As part of an EJR determination dated June 24, 2019, the Board notified QRS that the SoP for Case Nos. 14-4385GC and 14-4386GC had failed to comply with Board rule by "*improperly*" including Scottsdale Osborn Medical Center because the Board had previously issued a determination denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[42] As part of an EJR determination dated September 30, 2021, the Board admonished QRS for "*improperly*" including Mercy Hospital Springfield on the SoP for Case No. 14-4171GC and 14-4172GC because the Board had issued a jurisdiction determination on March 25, 201**5** dismissing the dual eligible days issue as untimely added to Case No. 14-0460 and denying transfer from Case No. 14-0460 to the respective group appeals. The Board reminded QRS that it has a responsibility to track and manage its cases and ensure it exercises due diligence prior to making filings.

[43] As part of an EJR determination dated April 11, 2019, the Board notified QRS that it had "*improperly*" included Lawrence & Memorial Hospital on the SoP for Case No. 15-0020G and 15-1423G because the Board previously issued a determination dated November 7, 2016 (as modified by letter dated December 12, 201**6**) denying jurisdiction over the Provider and its request to transfer to the respective group appeals.

[44] As part of an EJR determination dated April 4, 2019, the Board notified QRS that it had "*improperly*" included 3 different providers on both the SoP Case Nos. 14-0585GC and 15-0587GC because, by letters dated May 14, 2015, July 9, 2015, November 17, 2015, the Board had denied transfers of those 3 providers to both Case Nos. 14-0585GC and 15-0587GC.

[45] As part of an EJR determination dated April 12, 2019, the Board notified QRS that it had "*improperly*" included a provider on the SoP even though the Board had denied jurisdiction in the individual appeal and denied transfer therefrom on February 23, 201**6** and, *following a request for reconsideration*, ***upheld*** that denial by letter dated June 17, 201**6**.

[46] QRS failed to withdraw a provider from Case Nos. 15-1642GC, 15-1643GC, 15-1644GC, 15-1648GC, 15-2460GC, 16-1345GC, 16-1348GC, and 16-1349GC even though: (1) the Bankruptcy Settlement Agreement entered into between the Provider and the CMS in June 2021 required within 30 days of the Bankruptcy Settlement Agreement's effectuation to "withdraw their participation in PRRB Appeals . . . or appeals pending in any venue or jurisdiction"; (2) On September 1, 2021 ,the Medicare Contractor notified QRS by email of its obligation to withdraw per the agreement; and (3) on September 17, 2021, the Medicare Contractor filed a Request for Dismissal of that provider from these cases based on QRS' in action. Notwithstanding, QRS took no action and, in particular, did not respond within the 30 days allotted under Board Rule 44.3 and, accordingly, the Board dismissed the provider and reprimanded QRS for its failure to comply with the Bankruptcy Settlement Agreement.

[47] In a Board determination dated August 12, 2020 on a Medicare Contractor challenge to certain issue transfers, the Board reopened Case No. 17-0568 to dismiss 2 providers that had *improperly* transferred from 10+ month ***closed*** cases, and reopened and rescinded the EJR determination for Case No. 17-0568GC in order to effectuate the void/invalid

basic responsibilities and due diligence as a representative appearing before the Board. As a representative with more than 1,500 open cases (of which there are more than 1,000 CIRP groups and 130 optional groups), QRS should be intimately familiar with the need to track and account for withdrawals and dismissals in its filings of SoPs with the Board[48] as well as Board Rule 47 addressing how a dismissed or withdrawn provider may be reinstated to an appeal.[49]

Especially egregious examples of QRS's failure to competently fulfil its responsibilities as a Provider Representative *in 8 of the instant 80 group cases* include:

a. Case No. 13-1419G – On January10, 2022, 2 days prior to filing its EJR request, QRS refiled what it identified as its original SoP dated June 4, 2014.[50] However, nearly 6 years after filing the original SoP, and nearly 2 years before refiling it as part of its EJR request, QRS *filed* ***in OH CDMS***[51] its withdrawal of Participant #11, St. Francis North Hospital (Prov. No. 19-0197, FYE 6/30/2006, amount in controversy ("AiC") $330,000) on February 25, 2020. Under Board Rules, withdrawals are self-effectuating.[52] Despite its withdrawal, QRS has continued to improperly include St. Francis North Hospital on the Final Schedule of Providers and pursue reimbursement.

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transfers and dismissals. Further, the Board dismissed those same two providers from Case No. 19-2376GC as it had bifurcated from 17-0568GC and their participation in Case No. 19-2376GC depended on the validity of was dependent on that bifurcation. Finally, the Board admonished QRS, as the Group Representative (as well as the Representative in the individual cases) for submitting transfer requests from these individual appeals to Case No. 17-0568GC that they should have known were both invalid and void since the individual cases had been closed for over ten months when the transfer requests were made. The Board reminded them that as representatives they have the responsibility to track and manage their cases and ensure they exercise due diligence prior to making filings.

[48] The Board has identified one SoP where QRS noted withdrawals. The SoP for Case No. 15-0018G that is attached to the January 12, 2022 consolidated EJR request shows an example of an SoP where QRS *correctly* noted 2 separate providers that were previously withdrawn – Participant #3, Prov. No. 19-0125, on SoP-A and Participant #20, Prov. No. 33-0074, on SoP-B. Similarly, the cover letter to the SoP filed in Case No. 14-2217GC includes the withdrawal of 2 participants, Prov. Nos. 340158 and 34-0183, and neither of these withdrawn participants were included on the attached SoP.

[49] For example, QRS filed an *amicus curiae* brief in support of the hospitals position in the case, *Baptist Memorial Hospital-Golden Triangle v. Sebelius*, 566 F.3d 226 (D.C. Cir. 2009) ("*Baptist*"). In *Baptist*, the D.C. Circuit found the following: "Notwithstanding the clear directions in the [PRRB] Instructions, the hospitals *gamely* argue that they did not need to follow the Instructions to reinstate a previously **dismissed** appeal. . . . The hospitals cannot so easily evade the plain meaning of the Instructions. The relevant reinstatement provision quite clearly explains how to reinstate appeals for failure to file a timely position paper and lists certain requirements for doing so—including that the party "explain in detail" its reason for non-compliance." (Emphasis added.)

[50] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[51] The Board's electronic filing system is known as the Office of Hearings Case and Document Management System ("OH CDMS") and was launched on a voluntary basis in August 2018. The Board implemented mandatory electronic filing on November 1, 2021. The OH CDMS records readily available to the parties for Case No. 13-1419G show that Philip Payne of QRS filed the request for withdrawal on February 25, 2020 at 3:04 pm.

[52] *See* Board Rule 46 (stating "NOTE: A provider's request for withdrawal is self-effectuating and does not require any action by the Board once it is filed. Notwithstanding, the Board or Board Staff generally will issue a notice

b. Case No. 13-1440G – On January 10, 2022, 2 days prior to filing its EJR request, QRS refiled what is identified as its original SoP dated June 4, 2014.[53] However, by letter dated October 16, 2017, the Board issued its decision to QRS denying the transfer of Participant #14, Cape Fear Valley Medical Center (Prov. No. 34-0028, FYE 9/30/2006, AiC $38,000) from Case No. 13-3632 to Case No. 13-1440G. Notwithstanding the denial, QRS has continued to improperly pursue reimbursement for that provider on the Final SoP submitted with the instant EJR Request and failed to include the Board's dismissal in the documentation attached to that Schedule of Providers.

c. Case No. 13-2678G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoP dated October 27, 2014.[54] However, QRS failed to update the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2014 filing. Furthermore, QRS continues to pursue reimbursement on behalf of these Providers *after* they had been removed from Case No. 13-2678G.

   i. On April 29, 2015, QRS withdrew Participant #22, Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007, AiC $55,115).

   ii. On May 17, 2016, QRS withdrew Participant #18 Shands Jacksonville Medical Center (Prov. No. 10-0001, FYE 6/30/2007, AiC $24,000) following a Board request dated May 7, 2016 for QRS to provide a copy of the missing letter of authorization from the Provider.

   iii. On April 15, 2015, the Board notified QRS that, in connection with Participant #27 Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007, AiC $22,000) the Board was dismissing the DSH Dual Eligible Days (Medicaid and SSI Fraction), and other issues in Case No 13-1904 and denying transfer of that issue to 13-2678G.

d. Case No. 13-2693G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled roughly 4/5 of its original SoP, dated October 27, 2014,[55] and the

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acknowledging the withdrawal when it results in the closure of a case. The Board does not issue a similar notice when the withdrawal does not result in the closure of the case.").

[53] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated June 26, 2004 and the attached the SoP lists the "date prepared" as June 4, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 700+ pages of attachments.

[54] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the roughly 1950 pages of attachments.

[55] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated October 28, 2014 and the attached SoP lists the "date prepared" as October 27, 2014. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2130+ pages of attachments.

remaining 1/5 of that document on January 19, 2022, one week after filing its EJR request.[56] However, in December 2017, the Board notified QRS of its decision to deny transfer of Wuesthoff Memorial Hospital (Prov. No. 10-0092, FYE 9/30/2008) from Case No. 13-2106 to Case No. 13-2693G because the revised NPR at issue did not adjust the issue for which transfer was requested. Notwithstanding, QRS has continued to improperly pursue reimbursement for the Provider as Participant #26 on the SoP with an AiC of $115,000.

e. Case Nos. 13-3942G and 13-3944G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case Nos. 13-3942G and 13-3944G which are each ***dated December 2, 2012***.[57] However, on May 24, 2017, the Board notified QRS of its decision to deny the transfer of Rapid City Regional Hospital (Prov. No. 43-0077, FYE 6/30/2009) from Case No. 14-1297 to Case Nos. 13-3942G and 13-3944G because the Provider did not timely file its individual appeal request. Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #47 on the SoP for Case No. 13-3942G with an AiC of $21,000 and as Participant #44 on the SoP for Case No. 13-3944G with an AiC of $105,000.

f. Case No. 14-1816G—On January 11, 2022, one day prior to filing its EJR request, QRS refiled what it identified as its original SoPs for Case No. 14-1816G which is dated April 7, 2015.[58] However, on November 18, 2015, the Board notified QRS of its decision to deny the transfer of Larkin Community Hospital from Case No. 14-3904 because the Provider's original individual appeal request did not include the SSI fraction dual eligible days issue (nor was it timely added to the case). Notwithstanding, QRS continues to improperly pursue reimbursement for the Provider as Participant #8 on the SoP with an AiC of $44,000.

g. Case No. 14-1174G – On January 11, 2022, one day prior to filing its EJR request, QRS refiled its original SoP, dated March 20, 2015.[59] However, QRS failed to update

[56] As the SoP with supporting documentation and cover letter consists of 2137 pages, QRS divided the filing into 5 parts and uploaded parts 1, 2, 4 and 5 on January 11, 2022 and the missing part 3 on January 19, 2022, a week after it had filed the consolidated EJR request on January 12, 2022.

[57] While the cover letters transmitting the SoPs with supporting jurisdictional documentation for Case Nos. 13-3942G and 13-3944G are dated December 30, 2014 and December 26, 2014 respectively, each of the attached SoPs list the "date prepared" as December 2, 2012. Further, the caption for the filing in OH CDMS identifies these filings as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the aggregate roughly 3900 pages of attachments to these SoPs (1980+ pages for Case No. 13-3942G and 1900+ pages for Case No. 13-3944G).

[58] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated April 28, 2015 and the attached SoP lists the "date prepared" as April 7, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 863 pages of attachments.

[59] The cover letter transmitting the SoP with supporting jurisdictional documentation is dated March 31, 2015 and the attached SoP lists the "date prepared" as March 20, 2015. Further, the caption for the filing in OH CDMS identifies the filing as the "original submission" of the SoP. Accordingly, the Board is also assuming that there have been no changes to the 2250 pages of attachments.

the SoP to reflect the following dismissals and withdrawals that occurred subsequent to the original 2015 filing and, as such, is improperly pursing reimbursement on behalf of these providers.

i. By letter dated April 7, 2015, the Board notified QRS that the Board was dismissing Case No. 13-2753 for Bismarck MedCenter One (Prov. No. 35-0015, FYE 12/31/2007) in its entirety and denied transfer of the DSH SSI Fraction/Dual Eligible days issue to Case No. 14-1174G. QRS has continued to improperly pursue reimbursement for the Provider as Participant #39 on the SoP with an AiC of $50,000.

ii. By letter dated April 15, 2015, the Board notified QRS that the Board was dismissing all issues except the rural floor budget neutrality adjustment ("RFBNA") issue in Case No. 13-1904 for Union General Hospital (Prov. No. 11-0051, FYE 4/30/2007) because QRS *only* obtained authorization to act on behalf of the Provider for the RFBNA issue. Accordingly, the Board denied the transfer of the Dual Eligible Days (Medicaid & SSI fractions) issue from Case No. 13-1904 to Case No. 14-1174G. However, QRS has continued to improperly pursue reimbursement for the Provider as Participant #28 on the SoP with an AiC of $10,000.

iii. On April 29, 2015, QRS filed its request to withdraw Leesburg Regional Medical Center (Prov. No. 10-0084, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite its withdrawal, QRS continues to improperly pursue reimbursement for the Provider as Participant #23 on the SoP with an AiC of $138,000.

iv. On May 17, 2016, QRS filed its request to withdraw Shands Jacksonville (Prov. No. 10-0001, FYE 6/30/2007) from Case No. 14-1174G (among others). Despite this withdrawal, QRS has continued to improperly pursue reimbursement for the Provider as Participant #19 on the SoP with an AiC of $86,000.

4. Prohibited Participation of CIRP Providers in Optional Groups

There are additional violations, or potential violations, of the mandatory CIRP group requirements at 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R § 405.1837(b)(1). For example, on March 17, 2022 (several weeks prior to QRS' April 8, 2022 letter), the Board issued a request for additional information in two *optional* group cases (Case Nos. 19-2513G and 19-2515G), identifying potential CIRP compliance issues and QRS submitted a partial response.[60] The Board has a similar open inquiry from January 2021 on the participation of Deaconess Medical Center in Case No. 17-1412G notwithstanding the fact that the provider is part of Empire Health and Empire Health has an open CIRP group for the same issue and year under Case No. 17-0554GC. Upon further review, the Board would issue similar

[60] The mandatory CIRP regulation applies to commonly owned ***or*** *controlled* providers. QRS' response failed to address one provider and, for 2 providers, the response did not adequately address whether there was "control" (*e.g.*, control of the provider through a management agreement).

development letters for CIRP issues identified in other groups, including Case Nos. 13-1419G, 13-3942G, 13-3944G 15-0018G, 15-1419G, 15-3039G, and 16-1750.

5. *Unauthorized Representation of Participants*

   The Board has identified multiple situations where QRS failed to obtain proper authorization from the provider to be a participant in the relevant group. In these situations, the Board has dismissed the provider from the group. For example, in Case No. 13-1419G, QRS failed to provide documentation of proper authorization from Participant #2, Pacifica Hospital of the Valley ($13,000 AiC). Board Rule 5.4 (Mar. 2013) specifies that "[t]he letter designating the representative must be on the Provider's letterhead and be signed by an owner or officer of the Provider" and "must reflect the Provider's fiscal year under appeal." Contrary to Board Rule 5.4, the authorization letter is not on hospital letterhead and does not identify the organization to which the signatory belongs.

6. *Participants That Did Not Properly Transfer Into the Group or Only Transferred a Portion of the Issue/Issues Covered By the Group*.— The majority of the 950+ participants in these groups arrived by transfer from an individual appeal. For any participant that transfers into a group from an individual appeal, the Board must review whether the individual appeal properly included the issue the provider seeks to transfer. A provider can only transfer an issue that is properly existing in its individual appeal.[61] The Medicare Contractors, as discussed *infra*, have already identified issues with some transfers and the Board expects it would identify additional issues if it were to complete its jurisdictional review.

7. *Participants that Fail to Have Both Issues Covered by the EJR Request*.— The EJR request pertains to the DSH adjustment calculation and covers two separate issues where one pertains to the SSI fraction and the other to the Medicaid fraction as used in that calculation. Thus, for each year, a participant tends to be in two groups – one for the SSI fraction issue and one for Medicaid fraction issue. The Board is aware that some providers are participants in only one of the fraction groups (*e.g.*, a participant in the SSI fraction group but not the Medicaid fraction group or vice versa). In those instances, the Board must assess whether the provider can remain in the group and, if so, to what extent the EJR applies.

Notwithstanding the above jurisdictional issues and concerns, QRS made clear, in its April 8, 2022 filing, that it had abandoned the Board's jurisdictional review process as discussed above. QRS reinforced its intent in the Providers' response to the Board's Order to Show Cause, as shown by the following excerpts:

[61] The Board notes that the window in which issues can be added to an individual appeal is limited by regulation at 42 C.F.R. § 405.1835(e) which states in pertinent part: "After filing a hearing request in accordance with paragraphs (a) and (b), or paragraphs (c) and (d), of this section, a provider may add specific Medicare payment issues to the original hearing request by submitting a written request to the Board only if – . . . . (3) The Board receives the provider's request to add issues no later than 60 days after the expiration of the applicable 180-day period prescribed in paragraph (a)(3) or paragraph (c)(2), of this section." *See also* 42 C.F.R. § 405.1835(b) and Board Rule 8 for content and specificity requirements for issues being appealed.

- "The Board, however, failed to render its decision within the thirty-day period. Instead, partly at the request of FSS, the Board informed the Providers that the Board required an additional sixty days to review jurisdictional documents.[1]"

- Footnote 1, appended to the above quote, reads: "*The Providers are aware that there are other* ***extenuating circumstances***, such as COVID related staffing issues which are hampering the Board's ability to process EJR requests. While certainly sympathetic to those issues, the Providers believe that the statute's thirty-day deadline applies even if there are valid and compelling reasons why that deadline cannot be met. The Providers' filing of their EJR complaint, therefore, should not be viewed as casting aspersions on the pace with which the Board is addressing these issues in any way. It simply reflects the objective fact that a decision was not issued within thirty days."[62]

While QRS' April 8, notice did not provide the case number assigned to the Complaint the Providers filed in federal court, PACER (the federal courts' filing system) verifies that the Providers' Complaint, relevant to this decision, was filed in federal district court on February 14, 2022. However, QRS waited nearly two months (54 days) to notify the Board, FSS and the Medicare contractors of the Complaint and its position that the Board proceedings were otherwise

[62] Provider's Response to FSS' Request for Dismissal at n.1 (May 5, 2022). In this situation, it is unrealistic and naive for QRS to expect the Board to complete the prerequisite jurisdictional review process, as well as a review of the EJR request, itself within 30 days. The unreasonableness of QRS' position is highlighted by the following facts:

- The consolidated request consists of 80 cases involving over 950 participants;
- The SoPs with supporting documentation involve tens of thousands of documents. For example, the 8 cases identified as improperly listing previously dismissed/withdrawn participants (Case Nos. 13-1419G, 13-1440G, 13-2678G, 13-2693G, 13-3942G, 13-3944G, 14-1174G, and 14-1816G) involve, in the aggregate, nearly 12,500 pages of attachments which averages to roughly 40 pages per participant (12,473 pages/315 participants). Projecting that to the 950+, the Board estimates that the SoPs for these 80 cases involve over 37,000 pages of documentation related to jurisdiction.
- The majority of the cases at issue are legacy cases and were not filed initially in OH CDMS. As a result, the jurisdictional documentation was filed in hard copy.
- The Agency, including the Board has been in maximum telework status since March 2020 with limited and, at times, no access to hard copy files and filings. Indeed, during the 30 days immediately following the filing of the January 12, 2022 consolidated EJR request, the Baltimore/DC metro area was experiencing the effects of the surge in COVID-19 cases due to the Omicron variant and the Agency remained in maximum telework status and no staff members were in the Board's offices until mid-February 2022 when certain skeletal staff members began coming into the Board's offices. The Agency only lifted that status on May 23, 2022.
- Review and navigation of scanned PDF copies of SoPs is exponentially more time consuming that review of a hard copy SoP that is tabbed and documents can be accessed both horizontally and vertically. As set forth in Board Rule 21, the SoP is organized by participant (Tab 1 is participant 1, Tab 2 is participant 2, etc.) and each participant's jurisdictional documents are organized by Tabs A through H. An example of horizontal access is reviewing the jurisdictional documentation provider by provider. An example of horizontal access is solely looking at the representation letter housed behind Tab H of each provider and this type of access is important for purposes of consistency and quality control. As the PDF documents upload here do not have bookmarks, vertical navigation is not an immediate resource. Some of the optional groups are very large making navigation of an SoP, such as flipping between providers, very challenging. For example, Case No. 13-2693G involves 54 participants and the SoP is spread across 5 pdf documents containing 2137 pages, in the aggregate (and, again, contains no bookmarks to facilitate navigation).

"exhausted"/done.[63] This delay caused significant waste of the Board's limited resources, as well as those of FSS and the Medicare contractors servicing the 950+ participants in the 80 group cases.[64] More concerning is QRS' attempt to undermine, and bypass, the Board's regulatory and statutory duty to conduct a complete and thorough jurisdictional review process for all of the participants in these cases. QRS essentially self-declared that all 950+ participants in these groups have a right to pursue EJR in federal district court (regardless of whether the Board has jurisdiction over such providers, including instances of previously dismissed or withdrawn providers). If the Providers were successful on the merits of their claims in federal court, then bypassing the Board's jurisdictional review process could result in millions of dollars being improperly paid.[65]

Accordingly, based on QRS' failure to comply with the Board's filing deadline set forth in its Scheduling Order, the Board exercised its authority under 42 C.F.R. § 405.1869(b)(2) and required QRS to show cause why the Board should not dismiss the appeals in the attached listing based on:

- QRS' failure to timely respond to the Medicare Contractor's Extension Request or the Board's ensuing Scheduling Order to manage the Board's process for completing the requisite jurisdictional review.

- QRS' abandonment of the Board's ongoing jurisdictional review process, and refusal to comply with the Board's Scheduling Order for the management of that review process.

B. Board Deferment of its Order to Show Cause Why Dismissal is Not Appropriate

42 C.F.R. § 405.1842(h)(3) addresses how Provider lawsuits relating to an EJR request affect Board proceedings:

> (3) *Provider lawsuits*. (i) If the provider files a lawsuit seeking judicial review (whether on the basis of the EJR provisions of section 1878(f)(1) of the Act or on some other basis) pertaining to a legal question that is allegedly relevant to a specific matter at issue in a Board appeal to which the provider is a party and that is allegedly not within the Board's authority to decide, the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and a copy of the complaint.

[63] While the notice identified the jurisdiction in which the lawsuit was filed, it did not include either a copy of the complaint, the date the lawsuit was filed, or the case number established for the lawsuit.
[64] The Board takes administrative notice that it has a very large docket of pending cases (9485 as of April 1, 2022) and is processing many EJR requests involving multiple thousands of participants. As of April 8, 2022, ***in addition to*** *the 80 cases covered in this notice*, the Board had 253 cases with EJR requests pending of which 130 were filed by QRS. On or after April 8, 2022, EJR requests were filed for an additional 207 cases of which 154 were filed by QRS. As these cases were primarily group cases, they involved thousands of participants in the aggregate.
[65] As explained *supra*, a partial review of just 8, of the 80, group cases being pursued as part of the ongoing lawsuit reveals previously withdrawn/dismissed participants accounting for approximately $1 million in controversy on the related SoPs.

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> (iii) *If the lawsuit is filed before a final EJR request is issued on the legal question*, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[66]

The Board initially suggested, in its letter dated April 21, 2022, that the clause "proceedings on the legal question or matter at issue" in § 405.1842(h)(3)(iii) only addressed proceedings "on the substance of the EJR request and does not address pre-requisite jurisdiction or other procedural issues that may arise in an appeal or proceedings before the Board." However, upon further reflection, the Board agrees that this regulation ***bars any further Board proceedings*** in these 80 group cases, including proceedings on pre-requisite jurisdictional issues or other procedural issues. Consistent with FRCP 62.1, the Board issues this ruling on a Motion for Relief that is barred by a pending appeal and, as explained below, is deferring consideration of its Order to Show Cause until, or if, the Administrator remands these cases back to the Board.

In response to the Board's April 21, 2022 Order to Show Cause, QRS asserted that it "did not respond to the Board's deadlines or to the MAC's filings because the Providers commenced an action in federal court and *reasonably believed that further proceedings before the Board prohibited by regulation*."[67] QRS then stated that it "notified the Board by letter dated April 8, 2022 that [the Providers] had commenced an action in federal court" and that "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." QRS further stated that, based on § 405.1842(h)(3)(i), it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit" and "regret that apparently this did not happen, and we apologize for not doing more to proactively notify the Board regarding the filing of the complaint ourselves."

FSS in its May 5, 2022 response, suggested that QRS' response was disingenuous in presuming that the CMS Office of Attorney Advisor would promptly notify the Board of the Providers' lawsuit, filed by QRS, because QRS had failed to properly serve the Secretary until April 12, 2022 with an alias summons:

> Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a

[66] (Emphasis added.)
[67] (Emphasis added.)

> Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.

The Board subsequently reviewed the preambles to the proposed rule, dated June 5, 2004,[68] and the May 23, 2008 final rule[69] that promulgated the regulation at 42 C.F.R. § 405.1842(h)(3)(iii). The preamble to the proposed rule described this regulation as follows:

> Proposed § 405.1842(h)(3) would specify the effect that a provider lawsuit would have on the Board's ability to conduct further proceeding on the legal matter at issue. In general, if a provider files a lawsuit on the same legal issue for the same cost year that is currently pending before the Board - that is, the provider goes into court without waiting for a final administrative decision on EJR, we would seek to have the lawsuit dismissed, and we would prohibit the Board from conducting further proceedings on that issue until the lawsuit is resolved.[70]

The final rule includes additional guidance on § 405.1842(h)(3):

> *Comment*: One commenter stated that the proposed rule would provide that, if any allegedly relevant lawsuit was filed before a final EJR decision, the Board would be precluded from conducting any further proceedings on the EJR decision until the lawsuit was resolved, and that it appears that the proposed policy would apply, regardless of the basis for the lawsuit. The commenter suggested that the final rule provide that the Board be required to conduct further proceedings on an EJR decision when the provider subsequently files a lawsuit brought on jurisdictional grounds other than the Social Security Act. If the Board were allowed to grant EJR, the issues jurisdictionally under the Medicare statute could be added to the pending matter in court, thus preserving judicial resources and avoiding multiple lawsuits.
>
> *Response*: The commenter is correct that the proposed policy would apply regardless of the jurisdictional basis for the lawsuit. However, we decline to adopt the commenter's suggestion that we make a distinction based on the jurisdictional basis pleaded in the complaint. We do not agree that it would be appropriate for the Board or the

[68] 69 Fed. Reg. 35716 (June 25, 2004).
[69] 73 Fed. Reg. 30190 (May 23, 2008).
[70] 69 Fed. Reg. at 3572

> intermediary to spend its limited resources to spend time on a Board appeal if the provider has filed a complaint that involves a legal matter that is relevant to a legal issue in the Board appeal. If the court properly has jurisdiction over the appeal, the decision, that it or a higher court renders, may resolve the issue or issues in the Board case, or otherwise inform the Board in reaching a decision, or affect the parties' decision as to whether they should attempt to settle the Board case. On the other hand, where the basis for the court's jurisdiction is defective (which we believe would most likely be the situation when a provider attempts to file a complaint based on a legal issue related to an appeal still pending before the Board), a contrary rule would not discourage providers from filing improper appeals with the court. We believe our proposal to be in line with the general rule practiced by courts that an appeal to a higher court deprives the lower court of jurisdiction to conduct further proceedings until the appeal is resolved by the higher court.[71]

Based on the above explanation regarding the intent and purpose for 42 C.F.R. § 405.1842(h)(3)(iii), the Board finds that QRS' filing of the Complaint in the California Central District Court prohibits the Board from conducting any further proceedings on the EJR request for the cases as filed above, including any proceedings related to the prerequisite jurisdiction.

In so ruling, the Board notes that QRS created the confusion surrounding the status of these cases at the Board. QRS readily admits that, once it filed the Complaint in federal district court on February 14, 2022, they "*reasonably believed that further proceedings before the Board were prohibited by regulation*"[72] and stated that they did not notify the Board of that filing because, based on § 405.1842(h)(3)(i), they "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, the Board finds QRS' reliance on § 405.1842(h)(3)(i) to be misplaced and not made in good faith. Namely, it ignores both the Board's ruling in its January 24, 2022 Scheduling Order and the Providers' obligations under Board Rules. Pursuant to Board Rule 1.3 (Nov. 1, 2022),[73] QRS had a duty to communicate early and in good faith with the Board and the opposing party (in that regard the Secretary is not a party per 42 C.F.R. § 405.1843(b)):

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[71] 73 Fed. Reg at 30214-15.
[72] (Emphasis added.)
[73] The recent changes to the Rules (effective Nov. 1, 2021) were first published in June 16, 2021 and, in advance of their effective date, invited comments from all interested individuals, providers, government contractors and other organization to be submitted by July 30, 2021. Subsequently on September 30, 2021, based on its review of that feedback, the Board then published further revisions to the Rules (effective Nov. 1, 2021). *See* Board Order No. 1 (available at: https://www.cms.gov/files/document/revised-prrb-rules-v-30-cover-order-1-superseded-v-31.pdf); Board Alerts 21 and 22 (available at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/PRRBReview/PRRB-Alerts); Board Order No. 2 (https://www.cms.gov/files/document/current-prrb-rules-v-31-cover-order-2-november-1-2021.pdf).

> **1.3 Good Faith Expectations**
>
> In accordance with the regulations, the Board expects the parties to an appeal to communicate early, act in good faith, and attempt to negotiate a resolution to areas of misunderstanding and differences. The duty to communicate early and act in good faith applies to dealings with the opposing party, the Board, and/or any relevant nonparty.

Similarly, pursuant to Board Rule 5.2 (Nov. 1, 2021), QRS, as the Providers' representative, is responsible for being familiar with, and following, Board rules and procedures and governing regulations (including 42 C.F.R. § 405.1842(b)(2)), and timely responding to correspondence or requests from the Board or the opposing party:

> **5.2 Responsibilities**
>
> *The case representative is responsible for being familiar with the following rules and procedures* for litigating before the Board:
>
> - The Board's governing statute at 42 U.S.C. § 1395oo;
> - *The Board's governing regulations at 42 C.F.R. Part 405, Subpart R*; and
> - *These Rules*, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/ReviewBoards/PRRBReview/PRRB-Instructions (see Rule 1.1).
>
> Further, *the case representative is responsible for*:
>
> - Ensuring his or her contact information is current with the Board, including a current email address and phone number;
> - Meeting the Board's deadlines; and
> - *Responding timely to correspondence or requests from the Board or the opposing party*.
>
> Failure of a case representative to carry out his or her responsibilities is not considered by the Board to be good cause for failing to meet any deadlines. Withdrawal of a case representative or the recent appointment of a new case representative will also not be considered good cause for delay of any deadlines or proceedings.[74]

[74] (Italics emphasis added.) *See also, Baptist Mem'l Hosp.-Golden Triangle v. Sebelius*, 566 F.3d 226, 227 (D.C. Cir. 2009) wherein the Circuit Court affirmed the District Court's granting of summary judgment to the Secretary because the Providers failed to follow Board Rules, stating, "The court therefore granted summary judgment to the Board.

In response to the Board's April 24, 2022 Order to Show Cause, QRS asserted that "any theory of wholesale abandonment of so many appeals because the Providers decided to pursue those appeals in Federal court under a good faith understanding of the statute's requirement that the Board decides EJR requests within thirty days, and our good faith understanding that the filing of such a complaint halts further action before the Board, would be mistaken." Further, in its response, QRS is quick to assert that 42 U.S.C. § 1395oo(f)(1) obligated the Board (and the Medicare Contractors) to process its EJR request, ***and*** complete its jurisdictional review of those 80 group cases and the underlying 950+ participants, within 30 days of its filing the EJR request (*i.e.*, by Friday February 11, 2022). However, QRS' reliance on this position glosses over the record, and ignores how its silence interfered with the speedy, orderly and fair conduct of the Board proceedings (both in these cases and others) and prejudiced the opposing parties. Indeed, the following inaction on QRS' part belies its claim in the April 8, 2022 notice to the Board that "proceedings before the PRRB have been exhausted":

1. QRS did not notify the Board, FSS, or the Medicare Contractors, of its opposition to FSS' January 20, 2022 motion to extend the Medicare Contractor's time to file jurisdictional challenges until May 5, 2022, more than 3 months after that motion was filed.[75] Indeed, the tardiness of QRS' opposition is highlighted by the fact that it did not make its opposition known until after that extended deadline had passed by more than 50 days. QRS' failure to file notice with the Board, and serve FSS and/or the Medicare Contractors (*i.e.*, the opposing parties), of its opposition to FSS' request, violates QRS' obligations under Board Rules 1.3, 5.2, and 44.

2. QRS did not notify the Board of its objection to the Board's January 24, 2022 ruling on the extension, and the associated Scheduling Order, until May 5, 2022, more than 3 months after the fact. QRS' failure to file and preserve its objection to the Board's January 24, 2022 ruling and Scheduling Order violates QRS' obligations under Board Rules 1.3, 5.2, and 44 and deprived the Board of an opportunity to consider its ruling and Scheduling Order and, if necessary, correct or clarify that ruling and/or Scheduling Order.[76] The tardiness of QRS' opposition is again highlighted by the fact that it failed to make its opposition known until well after the extended deadline they complain of had passed.

Because the Board's procedural rules mean what they say and say what they mean, and because the hospitals did not follow them, we affirm."

[75] QRS' April 8, 2022 filing was 3 sentences long and did not provide this notice.

[76] While the Board is not bound by the FRCP, the Board refers to them for guidance and notes that the principles of FRCP 46 are similar. FRCP 46 applies to trial-like proceedings and "requires that a party seeking to preserve an objection to the court's ruling must 'make know to the court the action which the party desires the court to take or the party's objection to the action of the court and the grounds therefor.'" *Beach Aircraft Crop. v. Rainey*, 488 U.S. 163 (1988). *See also Cain v. J.P. Productions*, 11 Fed. Appx 714 (9th Cir. 2001). Similarly, the purpose behind Rule 46 is also relevant: "As pointed out in the discussions of Rule 46, the function of an exception was to bring pointedly to the attention of the trial judge the importance of the ruling from the standpoint of the lawyer and to give the trial judge an opportunity to make further reflection regarding his ruling. Proceedings of Institute, Washington, D.C., 1938, p. 87. In justifying the rule it was stated 'the exception is no longer necessary, if you have made your point clear to the court below.' Proceedings of Institute, Cleveland, 1938, p. 312. 'But of course it is necessary that a man should not spring a trap on the court * * *, so the rule requires him to disclose the grounds of his objections fully to the court.' Proceedings of Institute, Washington, D.C., 1938, p. 145; see also p. 87." *Bucy v. Nevada Const. Co.*, 125 F.3d 213, 218 (9th Cir. 1942).

3. On January 24, 2022, the Board made its position as to how the 30-day period to respond to the EJR request at issue, based on 42 U.S.C. § 1395oo(f), 42 C.F.R. §§ 405.1842(b)(2), 405.1801(d)(2)[77] and Board Alert 19, known to the parties in these cases. Specifically, the Board notified the parties that the Board had the authority to stay the start of the 30-day period since 42 C.F.R. § 405.1842(b)(2) specifies jurisdiction is a prerequisite to Board consideration of an EJR request. Because the Board was not operating normally – as evidenced by the fact that, during January 2022, all CMS offices (including the Board's) were closed to employees due to the surge of the COVID-19 Omicron variant. To that end, the Board issued its Scheduling Order to memorialize and effectuate the necessity to stay the jurisdictional review process and delay the start of the 30-day period to review the EJR request. QRS failed to notify the Board of its objection to the Board's January 24, 2022 Scheduling Order until May 5, 2022. QRS' failure to timely file, and preserve, that objection violates Board Rules 1.3, 5.2 and 44. QRS' delay also interfered with the speedy, orderly and fair conduct of the Board proceedings and prejudiced the Board by depriving it of an opportunity to reconsider its ruling and, if necessary, correct or clarify it,[78] or take other actions, ***prior to*** Friday, February 11, 2022 (*i.e.*, prior to the end of the alleged 30-day deadline from January 12, 2022). QRS' delay allowed the 30-day EJR review deadline, as alleged by QRS to be established in 42 U.S.C. § 1395oo(f)(1) (that QRS now alleges the Board missed), to pass, and, under QRS' strained interpretation that ignores the Secretary's regulations, permitted federal litigation to be pursued.[79]

4. In its January 24, 2022 Scheduling Order, the Board set forth its process for conducting jurisdictional review. In addition to specifying time for the Medicare Contractors to file jurisdictional challenges and the Providers to respond to those challenges, the Board included the following directive to the parties to supplement the record in these group cases "*to ensure the record before it in these group cases is* ***complete***"[80]:

> The Board's preliminary review of the EJR request using its legacy docketing system, Case Tracker, shows that some of the participants transferred from individual appeals and that, in some cases, the relevant MAC had filed jurisdictional objections to the dual eligible days issue in the individual appeal and there were Provider responses. Further, there appears to be situations where the Board did not resolve that jurisdictional challenge. ***To ensure the record before it in these group cases is complete***, *the Board requests the parties to upload copies of these briefs and any relevant Board*

[77] The Board's Notice was clear that a Board finding of jurisdiction is a prerequisite to any review of an EJR request citing to 42 C.F.R. §§ 405.1842(b)(2), (e)(2)(ii), (e)(3)(ii).
[78] For example, the Board could have explained how reliance solely on 42 U.S.C. § 1395oo(f)(1) would be misplaced given the Secretary's implementation of that statute at 42 C.F.R. § 405.1842 (including in particular § 405.1842(b)(2)) as promulgated in the May 23, 2008 final rule and the Secretary's explanation of that regulation in the June 5, 2004 proposed rule. *See supra* notes 70 and 71 and accompanying text.
[79] *See supra* note 76 (discussing how the FRCP supports the Board's position).
[80] (Emphasis added.)

> *rulings to the Office of Hearings Case and Document Management System ("OH CDMS") in the appropriate group case so that these documents may be considered as part of the Board's review of jurisdiction of the participants in these group cases.*

QRS blatantly disregarded, and failed to address the Board's directive, to supplement the record relative to jurisdiction.[81] *As the overwhelming majority of the 80 group cases* involved participants that transferred from individual cases formed under the legacy docketing system, the Board's directive applied to the great majority of the 80 group cases. The Board agrees with FSS' statement, in its April 18, 2022 Request for Dismissal, that "the Board's Orders are not aspirational and the Providers' basis for disregarding them is unsupported (and unsupportable) by either law or fact."

5. QRS' failure to promptly notify the Board that it had filed the lawsuit in the California Central District Court violates Board Rule 1.3, and prevented the Board and the Medicare Contractors from understanding the nature of QRS' position relative to the 30-day period specified in 42 U.S.C. § 1395oo(f)(1). This occurred, despite the fact that, at that point in time, QRS claimed to "reasonably believe[] that further proceedings before the Board were prohibited by [the] regulation" at 42 C.F.R. § 405.1842(h)(3)(iii). QRS points to the statement in 42 C.F.R. § 405.1842(h)(3)(i) that "the Office of the Attorney Advisor must promptly provide the Board with written notice of the lawsuit and copy of the compliant." QRS further contends that it "presumed that the Office of the Attorney Advisor within CMS would promptly notify the Board of the suit." However, that does not mean that QRS did not have an affirmative obligation to *promptly* notify the Board of the lawsuit, and a further specific obligation to notify the Board of the lawsuit based on the circumstances of the Board proceedings. The following circumstances make it clear that QRS had an affirmative obligation to notify the Board of the Complaint being filed, and that QRS should have been aware of that affirmative obligation:

    a. The Board, in its Scheduling Order, made clear its position that the 30-day period for responding to the EJR request had not yet commenced. Further, the Scheduling Order directed both parties to submit certain jurisdictional related information, over a 90-day time frame, relevant to these 80 group cases and the underlying 950+ participants.

    b. Both the Board and the Medicare Contractors were acting in reliance on the authority of that Scheduling Order.

[81] The Board notes that the Medicare Contractors *did respond* to this portion of the Scheduling Order and *did file* copies of pending/unresolved jurisdictional challenges in individual appeals that impact participants in these 80 group cases. Indeed, the Board believes that it was as a result of this directive that the Medicare Contractors identified previously withdrawn/dismissed providers where challenges in individual appeals had been resolved through dismissal/withdrawal and denial of transfers. *See supra* note 32 and accompanying text.

c. QRS' position is dependent upon promptly effectuating service on the Secretary, and FSS contends that this service was not actually effectuated until on April 12, 2022, more than two months later, when an alias summons was issued.[82]

These circumstances make clear that QRS had a duty, pursuant to Board Rule 1.3, "to communicate early and act in good faith [with regard] [] to dealings with the opposing party, the Board, and/or any relevant nonparty."[83] Indeed, QRS' failure to comply with Board Rule 1.3, by promptly notifying the Board, FSS and the Medicare Contractors of the lawsuit on or about February 14, 2022, prejudiced the Board, FSS and the Medicare Contractors in other matters. Specifically, it interfered with the speedy, orderly and fair conduct of the Board proceedings (on these and other cases) and deprived both the Board, and the Medicare Contractors, of the opportunity to decide whether to delay, or cease, work on the 80 group cases and the underlying 950+ participants in favor of other time-sensitive work such as ***other*** EJR requests filed by QRS and other representatives. Indeed, QRS' two-month delay in notifying the Board, and the opposing parties, of the lawsuit filed in the California Central District Court raises concerns about potential prejudicial sandbagging by QRS to benefit subsequent EJR requests that QRS filed on behalf of other providers between January 24, 2022 and April 8, 2022 (*i.e.*, the date QRS gave notification).[84] In this regard, the Board notes that QRS filed EJR requests covering 36 cases with more than 640 participants in the aggregate,[85] of which the overwhelming majority (*i.e.*, greater than 80 percent of the 640+ participants) is associated with a consolidated EJR request filed on

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[82] FSS letter dated May 9, 2022 (stating: "Though Providers filed their Complaint on February 14, 2022, they waited until April 8, 2022 (nearly two months later) to advise the Board that such a complaint had been filed. Providers contend that CMS was responsible for advising the Board of a complaint's filing but there is no record that the summons was served and on April 12, 2022, an alias summons was issued in the case. Such a summons would not be necessary if Providers had effected service in the first instance. Again, when Providers finally notified the Board that a Complaint had been filed, they failed to set forth their basis for contending that such a complaint was procedurally proper; they failed to even identify the complaint they had filed. Providers, likewise, failed to timely respond to any of the jurisdictional challenges raised by the MAC.").

[83] It is disingenuous for QRS to suggest in hindsight in its May 5, 2022 response to the Board's April 24, 2022 Order to Show Cause that "[t]he Providers did not respond to the Board's deadlines or to the MAC's filings because [on February 14, 2022] the Providers commenced an action in federal court and reasonably believed that further proceedings before the Board prohibited by regulation" and that "[t]he Providers notified the Board by letter dated April 8, 2022 that they had commenced an action in federal court" but "[i]t was not until two weeks later when the Providers received the Board's April 21, 2022 letter that the Providers became aware for the first time that the Board continued to believe that it retains responsibility over and would proceed with these cases." The Board made its position known in its January 24, 2022 Notice of Stay and Scheduling Order and to the extent QRS had any doubts it had an obligation to seek clarification from the Board. Again, the Board's January 24, 2022 Notice of Stay and Scheduling Order was not aspirational and the Providers' basis for disregarding it is unsupported (and unsupportable) by either law or fact.

[84] *See Fink v. Gomez*, 239 F.3d 989 (9th Cir. 2001) ("[T]he cases discussed above make clear that sanctions are available if the court specifically finds bad faith or conduct tantamount to bad faith. Sanctions are available for a variety of types of willful actions, including recklessness when combined with an additional factor such as frivolousness, harassment, or an improper purpose. Therefore, we hold that an attorney's reckless misstatements of law and fact, when coupled with an improper purpose, such as an attempt to influence or manipulate proceedings in one case in order to gain tactical advantage in another case, are sanctionable under a court's inherent power.").

[85] On February 11, 2022, QRS filed a consolidated EJR request covering 10 group cases with 46 participants, in the aggregate. On February 27, 2022, QRS filed a consolidated EJR request covering 12 group cases with roughly 520 participants, in the aggregate. On March 9, 2022, QRS filed a consolidated EJR request covering 14 group cases with 76 participants, in the aggregate.

February 17, 2022[86] just days after the February 14, 2022 lawsuit was filed.[87] To this point, it is the Board's understanding that, ***prior to*** *the April 8, 2022 notice*, QRS filed an Amended Complaint on March 30, 2022 incorporating these other EJR requests into the lawsuit pending in the California Central District Court (or into new sister lawsuits filed therein).[88] Moreover, it is the Board's understanding that another representative, Healthcare Reimbursement Services, Inc. ("HRS") contemporaneously filed consolidated EJR requests covering 120 group cases with 569 participants in the aggregate,[89] and has joined QRS in lawsuits filed in the California Central District Court, including the one involved with the instant 80 group cases.[90]

As part of its April 8, 2022 notice to the Board, QRS clearly stated that it was abandoning the Board's jurisdictional review process and not complying with the Board's January 24, 2022 Scheduling Order when they stated in their April 8, 2022 filing: "*the Providers consider that proceedings before the PRRB have been* ***exhausted***[and] [a]ccordingly, the ***PRRB's previously established due dates no longer apply*** to the Providers."[91] Further, it is clear the Providers are pursuing the merits of their cases as part of the lawsuit. Pursuant to 42 C.F.R. § 405.1842(h)(3)(iii), the Board is prohibited from further proceedings in these cases. Therefore, the Board must close these cases.[92]

However, the Board cannot permit QRS' reckless disregard for its ***basic*** responsibilities and due diligence, as a representative appearing before the Board (including but not limited to failure to track and account for withdrawn/dismissed providers), its abandonment of the jurisdictional review process, and its disregard for the Board's authority, orders and process, to remain unanswered. Accordingly, if these cases are remanded, the Board will complete its jurisdictional review and weigh the severity of QRS' violations of, and failure to comply with, Board Rules, regulations and Orders, the prejudice to the Board and the opposing parties, and the interference with the speedy, orderly and fair conduct of the Board proceedings (regarding both these cases and others), and the

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[86] The January 17, 2022 consolidated EJR request covers 12 cases: Case Nos. 13-2324GC, 13-2328GC, 14-1072GC, 14-1073GC, 15-0580GC, 15-0586GC, 15-1622GC, 15-1624GC, 16-0678GC, 16-0679GC, 17-0575GC, and 17-0577GC.
[87] QRS waited until May 19, 2022 to file notice to the Board and the opposing parties that it had filed a lawsuit covering the 12 group cases covered by the February 17, 2022 consolidated EJR request.
[88] The Board will be addressing the status of these other cases under separate cover shortly.
[89] On December 29, 2021, HRS filed a consolidated EJR request covering 63 group cases with 255 participants, in the aggregate. On January 17, 2022, HRS filed a consolidated EJR request covering 40 cases with 200 participants, in the aggregate. On February 27, 2022, HRS filed a consolidated EJR request covering 17 group cases with 114 participants, in the aggregate.
[90] The Board will be addressing the status of these other cases under separate cover shortly.
[91] Board Scheduling Order at n.23 (Apr 21, 2022) (emphasis added).
[92] As noted in 42 C.F.R. § 405.1837(a), a group appeal may only have "a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group." Similarly, as explained at 42 C.F.R. § 405.1842(d), "[a] provider (or, in the case of a group appeal, a group of providers) may request a determination by the Board that it lacks the authority to decide a legal question relevant to a specific matter at issue in an appeal." Accordingly, the Board must assume there are no other issues, particularly since: (1) the existence of other issues would necessarily mean that the Board would not have jurisdiction over the group until that defect was cured; and (2) the Providers did not identify any concurrent issues with the filing of the consolidated EJR request but rather claimed therein that the Board had jurisdiction over the groups.

effect on the operations of the Board, when determining what, if any, remedial actions will be taken. Examples of available remedial actions that the Board may consider include, but are not limited to:

1. Dismissal of the 80 group cases and all underlying participants.
2. Dismissal of any group case in which the Board identifies any jurisdictional or material procedural errors occurred, whether by one participant or more.
3. Dismissal of any participant for which there is an open jurisdictional challenge regardless of the merit of such challenge.

These potential actions are well within the Board's authority pursuant to 42 C.F.R. § 405.1868(a)-(b),[93] as confirmed in the preamble to the May 23, 2008 final rule:

> Most of the comments we received on this subject came from providers, and reflect a perceived disparate treatment by the Board when a provider, rather than an intermediary, fails to follow a procedural rule or timeframe set by the Board. We proposed two possible actions by the Board, one applicable to a provider and the other applicable to an intermediary. That is, the worst case scenario for a provider would be a dismissal of the appeal by the Board, while the harshest remedy for an intermediary would be the issuance of a decision by the Board based on the written record established at the point of the intermediary's violation. However, we note that, because providers are the proponents of a case, they are responsible for moving the case forward by meeting all deadlines. Additionally, at section 1878(e) of the Act, the Congress has given the Board authority to make rules and establish procedures to carry out its function. Moreover, we note that the Board will have broad discretion to weigh the particular facts at hand in order to decide whether or not an offense merits remedial action.
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> ****
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> Again, we are clarifying that the proposed rule did not identify a complete listing of all potential Board sanctions. The Board has the

[93] 42 C.F.R. § 405.1868 states:

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

(b) If a provider fails to meet a filing deadline or other requirement established by the Board in a rule or order, the Board may -

(1) Dismiss the appeal with prejudice;

(2) Issue an order requiring the provider to show cause why the Board should not dismiss the appeal; or

(3) Take any other remedial action it considers appropriate.

(Emphasis added.)

> authority to take appropriate action against either party for procedural violations, but appropriate action does not necessarily mean a dismissal or the early issuance of a decision by the Board. We believe that these provisions will alert both parties that the Board has a mechanism in place to effectively stop a delaying tactic, or to redress other procedural violations. As a result, the parties should be less inclined to ignore procedural requirements and, accordingly, be more motivated to meet the deadlines set by the Board.[94]

* * * * *

In summary, 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings, because the Providers are pursuing the merits of their appealed issue in the California Central District Court, and there are no remaining issues beyond the EJR request.[95] Accordingly, the Board hereby closes these cases and removes them from the Board's docket. No further proceedings will occur, except upon remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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For the Board:

6/10/2022

X Clayton J. Nix

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

Enclosures: List of Groups

cc: Bill Tisdale, Novitas Solutions
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[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***
22-0605GC - *Hackensack Meridian CY 2019 Direct Graduate Medical Education (DGME) Penalty to FTE Count CIRP Group*
22-0769GC - *UPMC CY 2019 DGME Penalty to FTE Count CIRP Group*
22-0839GC - *Ohio State Health Sys. CY 2018 DGME Penalty to FTE Count CIRP Group*
22-0962GC - *Northwell Health CY 2018 DGME Penalty to FTE Count CIRP Group*

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 8, 2022 request for expedited judicial review ("EJR").[1] On April 27, 2022, the Board granted Federal Specialized Services ("FSS") an extension of time to respond to the EJR request. The Board has not received a response from FSS in the above-captioned group appeals, and the filing deadline for doing so passed on June 24, 2022.[2] The jurisdictional decision of the Board and its determination on EJR is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> . . . the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii) implementing the direct graduate medical education ("DGME") cap on full-time equivalent ("FTE") residents and the FTE weighting factors. . . . [The Providers assert that] [t]he regulation at 42 C.F.R. § 413.79(c)(2)(iii) is contrary to the statute because it determines the cap after application of weighting factors.[3]

[1] The EJR request was for a total of seven cases. The 3 remaining cases, Case Nos. 22-0846, 22-0918 and 22-0889GC, will each be addressed in separate determination letters.
[2] On June 28, 2022, the Board received a renewed EJR request for these 4 appeals as well as the 3 cases not addressed in this determination. The Provider representative acknowledged in that correspondence that the MAC had not submitted jurisdictional comments by the June 24th deadline, and therefore the cases were ripe for EJR decision. This determination will dispose of both the April 8, 2022 EJR request and the June 28, 2022 EJR renewal for these four group appeals.
[3] Provider's Petition for Expedited Judicial Review at 1 (Apr. 8, 2022) (hereinafter "EJR Request") (citing 42 U.S.C. § 1395ww(h)(4)(F)).

Background

The Medicare statute requires the Secretary[4] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME"). [5] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[6]

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.[7]

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

The Medicare Statute

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

> (C) . . . [I]n calculating the number of full-time equivalent residents in an approved residency period---
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> (ii) . . .for a resident who is in the resident's initial residency period . . . the weighting factor is 1.0 . . .
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> (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[8] ("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

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[4] of the Department of Health and Human Services.
[5] 42 U.S.C. § 1395ww(h).
[6] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[7] 42 U.S.C. § 1395(h).
[8] "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")[9] 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 include 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.[10]

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.[11] 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.
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> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting

[9] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[10] 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.
[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 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.
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> ·*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. . . .
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> 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. . . .
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> *****
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> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[12]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[13] 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

[12] 62 Fed. Reg. at 46005 (emphasis added).
[13] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> 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.[14]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[15] 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.[16]

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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[14] *Id.* at 39894 (emphasis added).
[15] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[16] 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.[17]

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.[18]

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 in these appeals are all teaching hospitals that receive DGME payments.[19] During the cost years included in these appeals, the Providers' FTE counts exceeded their FTE caps.[20] The Providers are requesting that the Board grant EJR as to the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the DGME cap on FTE residents and the FTE weighting factors.[21] Specifically, the Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2) is contrary to "the statute" because it determines the cap after application of the weighting factors.[22] The Providers explain that the effect of the "unlawful" regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the IRP, and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute, which the Providers refer to as the "fellowship penalty." The Providers argue that the calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and results in the Provider's DGME payments being understated.[23]

Addressing these contentions more fully, the Providers argue that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FTEs are capped before application of weighting factors.[24] The Providers claim that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this

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[17] 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.")
[18] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[19] EJR Request at 8.
[20] *Id.*
[21] *Id.* at 1 (citing 42 U.S.C. §§ 1395oo(f)(1); 42 C.F.R. § 405.1842(d))
[22] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)).
[23] *Id.*
[24] *Id.* at 10.

statute because it determines a cap after application of the weighting factors to fellows in the current year.[25]

Second, the Providers argue that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[26] Finally, the Providers claim "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[27]

The Providers allege that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the Providers from reaching their FTE caps and treats similarly situated hospitals differently.[28] Finally, the Providers state that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[29]

The Providers explain that some of the Providers in these cases expressed dissatisfaction with CMS' regulation by protesting this issue on their cost reports, and others self-disallowed this issue based on the MAC being bound by the regulation at 42 C.F.R. § 413.79(c)(2) and the Providers' challenge to that regulation.[30] The Providers argue that the Board has jurisdiction over the appeals even where there was not a protest item, because the Providers are dissatisfied with final determinations made by MACs as dictated by 42 C.F.R. § 413.79(c)(2), and the Medicare statute at 42 U.S.C. § 1395oo entitles the Providers to appeal a legal challenge to a Medicare regulation without including a protest item on the Medicare cost report.[31]

The Providers argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant their request for EJR.[32] In sum, the Providers assert that the regulation, 42 C.F.R. § 413.79(c)(2), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

The Medicare Contractors have not filed a response to the EJR Request in these four group appeals, and the time for doing so has elapsed.[33]

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) (2022), 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

[25] *Id.* at 10-11.
[26] *Id.* at 11-13.
[27] *Id.* at 13.
[28] *Id.* at 15.
[29] *Id.* at 15-16.
[30] *Id.* at 17-18.
[31] *Id.* at 18, *citing Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) and *Banner Heart Hosp. v. Burwell,* 201 F. Supp. 3d 131 (D.D.C. 2016).
[32] *Id.* at 21.
[33] Ruling on FSS' Extension Request Relating to Case Nos. 22-0605GC, *et al.,* at 2 (Apr. 25, 2022).

decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

The Providers' documentation shows that the estimated amount in controversy in each of the four group appeals exceeds $50,000, as required for a group appeal.[34] The appeals were timely filed and no jurisdictional impediments have been identified. Based on the above, the Board finds that it has jurisdiction over the four above-captioned group appeals.

A. Board Review of Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. §§ 405.1873 and 413.24(j) for Cost Reports Beginning on or After January 1, 2016

The Providers appealed from Worksheet E-4 with cost reporting periods beginning after January 1, 2016 and, therefore, are subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[35] 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.[36]

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[37] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[38] In these group cases, the Medicare Contractor has failed to file a Substantive Claim Challenge.

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[34] *See* 42 C.F.R. § 405.1837.
[35] 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").
[36] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[37] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[38] *See* 42 C.F.R. § 405.1873(a).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[39] the Board finds there was no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered and no substantive claim findings are required to be issued by the Board as part of this EJR determination.

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.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [40]

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.[41] 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.[42] 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).

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[39] Board Rule 10.2 provides that "[i]f 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."

[40] EJR Request at 10.

[41] *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.)).

[42] 66 Fed. Reg. at 39894 (emphasis added).

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].[43]

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.[44] 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."[45] 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[46] (*i.e*., ratios) using variables a, b, c, and d:

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

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

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[43] (Emphasis added.)
[44] *See* 62 Fed. Reg. at 46005 (emphasis added).
[45] *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.)).
[46] 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.

expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[47]

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

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

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

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

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

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

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the Providers in these group 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;

[47] 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 the rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject years.

The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal. As there are no issues remaining in these appeals, the Board hereby closes them 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:

7/13/2022

X Clayton J. Nix

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

cc: Bruce Snyder, Novitas Solutions, Inc.
Judith Cummings, CGS Administrators
Danelle Decker, National Government Services, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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July 14, 2022

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Pamela VanArsdale
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National Government Services, Inc. (J-6)
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RE: Dismissal of HealthEast St. John's (24-0210) FYE 10/1/2004-8/31/2005
HealthEast 2005 -2007 DSH SSI Medicare + Choice CIRP Group
PRRB Case Number: 13-2400GC

Dear Mr. Rose and Ms. VanArsdale:

In a Request for Information ("RFI") issued on March 2, 2022, the Provider Reimbursement Review Board (the "Board") advised the Provider's Representative that it must supply, by April 1, 2022, a copy of the Model Form D (Transfer Form) for HealthEast St. John's (Prov. No. 24-0210) ("St. John's") for FYE 2005. The Board explained, in the RFI, that the Transfer Form was required to document the transfer of the DSH SSI Medicare + Choice issue from the Provider's individual appeal, Case No. 07-2475, to Case no. 09-2032GC (the group case from which this case was bifurcated). The Board also advised the Representative that the copy of Model Form D supplied with the Schedule of Providers in this case, verified the transfer of the SSI issue for St. John's to Group Case No. 09-2318GC, - not the DSH SSI Medicare + Choice issue to Case No. 09-2032GC. Because the Representative failed to provide the required documentation by the April 1, 2022 deadline, the Board hereby dismisses St. John's (Prov. No. 24-0210) from Case No 13-2400GC. The Parties will receive further documentation regarding the applicability of CMS Ruling 1739-R for the remaining participants under separate cover. for the period 10/1/2004 through 8/31/2005

Board Members Participating:
Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq.
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FOR THE BOARD:

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Board Member

cc: Wilson C. Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***Jurisdictional Determination***
Salinas Valley Memorial Hospital (Prov. No. 05-0334)
FYE 6/30/2017
Case No. 21-1651

Dear Ms. Ellis and Ms. Frewert:

The Provider Reimbursement Review Board ("Board") has reviewed the subject individual appeal filed by Toyon Associates, Inc. ("Toyon" or "Representative") subsequent to a review of the same Provider's participation in two *optional* group appeals from the ***same*** determination. The pertinent facts with regard to the Provider's appeal and the jurisdictional determination of the Board, are set forth below.

Pertinent Facts

On August 30, 2021, Toyon filed a request to establish an individual appeal under Case No. 21-1651 for Salinas Valley Memorial Hospital (05-0334) ("Salinas Valley" or "Provider") for calendar year ("CY") 6/30/2017. The individual appeal includes two issues:

1) DSH Accuracy of CMS Developed SSI Ratio; and
2) DSH Inclusion of Medicare Part C Days in the SSI Ratio.

The appeal was filed from a Notice of Corrected Reimbursement issued as a result of the Provider's request for realignment.[1]

Based on a review of the supporting documentation, it is noted that:

- On July 8, 2020, Toyon requested a Reopening for Salinas Valley "request[ing] a recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year." This reopening request was made "pursuant to 42 CFR 412.106(b)(3)" which is the regulation governing requests to realign the SSI ratio (as used in the DSH adjustment calculation) from the federal fiscal year to a provider's fiscal year.

[1] Salinas Valley's final determination from which it is appealing is titled "Notice of Corrected Reimbursement," referred to hereinafter as "RNPR."

- On August 7, 2020, the MAC issued the Notice of Reopening "To adjust the SSI ratio used to calculate the Provider's disproportionate share adjustment based on the data from the hospital's actual cost reporting period *rather than the federal fiscal year*. [2]

- On March 1, 2021, the Medicare Contractor issued the RNPR.

- The adjustment being appealed from the RNPR is Audit Adjustment No. 4. Adjustment 4 described as the "SSI ***realignment*** adjustment per updated SSI% from CMS" effectively changing the SSI percentage from 10.05 to 10.23.[3]

On May 12, 2022, Federal Specialized Services, Inc. ("FSS") filed a jurisdictional challenge in which it objected to the Board's jurisdiction over the two issues under appeal. FSS contends that neither the SSI Ratio Data Accuracy, nor the DSH SSI Ratio Medicare Managed Care Part C Days issues were adjusted in the RNPR. In addition, FSS contends that the issues appealed are duplicative of issues being pursued in optional groups, Case Nos. 20-0956G and 20-2047G.

On June 9, 2022, Toyon responded to the jurisdictional challenge. Toyon contends that the Board does have jurisdiction because when the new SSI ratio was issued as a result of the realignment, new days were added to the calculation of the SSI ratio from the period 10/1/2016 through 6/30/2017.

Salinas Valley's Direct Add Requests to optional groups:

Prior to filing the individual appeal for Salinas Valley, on August 20, 2021, Toyon requested that the Board reopen the status of two optional groups to allow the addition of Salinas Valley's appeal from its RNPR:

- Case No. 20-0956G for "Toyon Associates CY 2017 Accuracy of CMS Developed SSI Ratio Group" and
- Case No. 20-2047G for "Toyon Associates CY 2017 DSH Medicare Part C - SSI Ratio/DE Part C - Medicaid Ratio Group."

The Board has not yet issued a determination on these requests. The Parties will receive such determination under separate cover.

Board's Determination:

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

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

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2018), 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 (2018) explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determinationor a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

Further, this regulatory limitation is cross-referenced in the provider right to a hearing in 42 C.F.R. § 405.1835(a) as follows:

> (a) *Right to hearing on final contractor determination*. A provider .. . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination isreopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).
>
> (2) The amount in controversy (as determined in accordance with § 405.1839) must be $10,000 or more.

> (3) Unless the provider qualifies for a good cause extension under § 405.1836, the date of receipt by the Board of the provider's hearing request must be no later than 180 days after the date of receipt by the provider of the final contractor or Secretary determination.[4]

Accordingly, pursuant to 42 C.F.R. § 405.1889(b) (and § 405.1835(a)(1) which references that regulation), the Board has jurisdiction only over those matters that have been "specifically revised" in a revised determination. More specifically, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[5]

Here, the Board finds that it does not have jurisdiction over the SSI Accuracy and Medicare Part C Days issues for Salinas Valley (05-0334) appealed from the RNPR because the RNPR was issued as a result of the Provider's SSI Realignment request, and did not adjust either of the two issues under appeal in this individual appeal. 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
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[6]

[4] (Emphasis added.)
[5] 42 C.F.R. § 405.1889(b)(1).
[6] (Emphasis Added.)

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[7] 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 Medicaredata derived *from the data match process* ***for the two Federal fiscal years thatspanned the hospital's cost reporting period***."[8]

2. *70 Fed. Reg. 47278, 47439 (Aug. 12, 2005)*.—"Under current regulations at § 412.106(b)(3), a hospital may request to have its Medicare fraction recomputed based on the hospital's cost reporting period if that year differs from the Federal fiscal year. This request may be made only once per cost reporting period, and *the hospital* ***must accept*** *the resulting DSH percentage for that year, whether ornot it is a more favorable number than the DSH percentage based on the Federal fiscal year. . . .*

   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."[9]

Accordingly, contrary to Toyon's assertion, the realignment process does not change any of the data underlying the realigned SSI fraction and does not add new days (*e.g*., Part C 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* (*i.e*., no need to change the days or data) in order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year and does not use any data matching process to achieve the new SSI value).

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[7] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[8] (Emphasis Added.)
[9] (Emphasis Added.)

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 RNPR was an adjustment related to realigning the SSI percentage from the Federal fiscal year to the hospital's fiscal year, the Provider (Salinas Valley) does not have a right to appeal the SSI Accuracy or Medicare Part C Days issues under 42 C.F.R. §§ 405.1889(b) and 405.1835(a)(1). The Board hereby closes Case No. 21-1651 and removes it from the docket. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[10]

Indeed, the Provider has already previously appealed these ***same*** two issues *from its original NPR* where: (a) it was transferred to Case No. 20-0956G for the SSI Accuracy Issue; and (b) it was transferred Case No. 20-2047G for the Medicare Part C days. The Provider is still an active participant in these cases based on the *original NPR* appeal.

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

Board Members Participating:
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Ratina Kelly, CPA

For the Board:

7/18/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services, Inc.
Dylan Chinea, Toyon Associates, Inc.

[10] *See St. Mary's of Mich. V. Azar*, No. 18-01790, 2020 WL 4049912 (D.D.C. July 20, 2020); *McLaren Flint v. Azar*,No. 18-2005, 2020 WL 2838566 (D.D.C. May 31, 2020), *Emanuel Med. Ctr., Inc. v. Sebelius*, 37 F.Supp.3d 348 (D.D.C. 2014); *HCA Health Servs. of OK v. Shalala*, 27 F.3d 614 (D.C. Cir. 1994).

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Via Electronic Delivery

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Bass, Berry & Sims, PLC
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Washington, D.C. 20004

RE: ***EJR Determination***
Keck Hospital of USC (University of Southern California) (Prov. No. 05-0696)
FYE 09/30/2017
Case No. 22-0918

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's April 8, 2022 request for expedited judicial review ("EJR"). In this case, by letters dated April 15 and 22, 2022, Federal Specialized Services ("FSS") requested an extension of time to respond to the EJR request in this appeal, which is a combined EJR request for a total of seven cases, the remaining six of which will be addressed in separate determination letters.

In the April 22, 2022 letter, FSS indicated that the Medicare Administrative Contractor ("MAC") notes that the Provider in this case failed to list any adjustments related to the appeal issue and that the appeal issue was not listed in the Provider's protested amounts listing. FSS indicated that a substantive challenge was being prepared and would be filed in due course, however, no further filings were made by FSS in this case and the deadline to do so has now passed. The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

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

[1] Provider's EJR Request at 1 (citing 42 U.S.C. § 1395ww(h)(4)(F)).

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.

The Medicare Statute

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

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

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

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[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

[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).

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

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

> *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

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

> 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 § 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 were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.

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 Provider's Position

The Provider is requesting that the Board grant EJR as to the validity of the regulation at 42 C.F.R. § 413.79(c)(2) implementing the DGME cap on FTE residents and the FTE weighting factors.[17] Specifically, the Provider asserts that the regulation at 42 C.F.R. § 413.79(c)(2) is contrary to "the statute" because it determines the cap after application of the weighting factors.[18] The Provider explains that the effect of the "unlawful" regulation is to impose on the Provider a weighting fact that results in a reduction of greater than 0.5 for many residents who are beyond the IRP, and it prevents the Provider from claiming their full unweighted FTE caps authorized by statute, which the Provider refers to as the "fellowship penalty." The Provider argues that the calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and results in the Provider's DGME payments being understated.[19]

Addressing these contentions more fully, the Provider argues that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FTEs are capped before application of weighting factors.[20] The Provider claims that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this statute because it determines a cap after application of the weighting factors to fellows in the current year.[21]

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[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] *Id.* at 1 (citing 42 U.S.C. §§ 1395oo(f)(1); 42 C.F.R. § 405.1842(d))
[18] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)).
[19] *Id.*
[20] *Id.* at 10.
[21] *Id.* at 10-11.

Second, the Provider argues that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[22] Finally, the Provider claims "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[23]

The Provider alleges that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the Provider from reaching its FTE cap and treats similarly situated hospitals differently.[24] 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.[25]

The Provider acknowledges that it did not protest this issue on its Medicare cost report, and that the Medicare Contractor did not implement an audit adjustment applicable to this issue.[26] Nonetheless, in the EJR Request, the Provider claims that it meets the jurisdictional dissatisfaction requirement for this issue because it self-disallowed the amount sought based on the Medicare Contractor being bound by the regulation at 42 C.F.R. § 413.79(c)(2) and the Provider's challenge to that regulation.[27]

The Provider 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 their request for EJR.[28]

The MAC noted a substantive claim challenge in this case in the request for extension of time to respond. Neither FSS or the MAC filed any further responses to the EJR Request and the time for doing so has now elapsed.[29]

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[22] *Id.* at 11-13.
[23] *Id.* at 13.
[24] *Id.* at 15.
[25] *Id.* at 15-16.
[26] Provider's Issue Statement at 2.
[27] EJR Request at 17-21 (citing and discussing *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) and *Banner Heart Hosp. v. Burwell,* 201 F. Supp. 3d 131 (D.D.C. 2016) to support the assertion that the Board has jurisdiction over the Provider's appeal because the Medicare statute at 42 U.S.C. § 1395oo entitles the Provider to appeal a legal challenge to a Medicare regulation without including a protest item on the Medicare cost report, notwithstanding the 2008 protest item regulation, and arguing that the court's reasoning in those two decisions applies equally to the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j)).
[28] *Id.* at 21.
[29] Addendum to Ruling on FSS' Extension Request Relating to Case Nos. 22-0605GC, *et al.,* at 2 (Apr. 27, 2022).

Decision of the Board

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

A. Compliance with requirements for filing a Board appeal

The Provider in this case appealed from the Medicare Contractor's Notice of Program Reimbursement dated September 27, 2021. The Provider filed a timely appeal. The amount in controversy exceeds the $10,000 threshold. Accordingly, the Board finds that it has jurisdiction over this case pursuant to 42 C.F.R. § 405.1835.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. §§ 405.1873 and 413.24(j)

1. Regulatory Background

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

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

> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[30]

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

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

[30] (Bold and underline emphasis added.)

> **granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .[31]

These regulations are applicable to the cost reporting periods in this case, which begins on October 1, 2016.

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

As explained above, at issue in this appeal is the cost report beginning after January 1, 2016, which is subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[32] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[33] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[34] 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.[35]

In this case, FSS indicated in its request for an extension of time dated April 22, 2022 that a substantive claim challenge was being prepared for the Provider because it failed to list any adjustments related to the appeal issue and that the appeal issue was not listed in the Provider's protested amounts listing.[36] Indeed, in its initial appeal request, the Provider appears to concede this because, in the appeal request, it stated that it did not protest this issue on its Medicare cost report, and the MAC did not implement an audit adjustment applicable to this issue. Similarly, in the EJR Request, the Provider claims that it meets the jurisdictional dissatisfaction requirement for this issue because it self-disallowed the amount sought based on the Medicare

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[31] (Bold and underline emphasis added.)
[32] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[33] (Emphasis added.)
[34] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[35] *See* 42 C.F.R. § 405.1873(a).
[36] Response to Providers' Request for Expedited Judicial Review (Apr. 22, 2022).

Contractor being bound by the regulation at 42 C.F.R. § 413.79(c)(2) and the Provider's challenge to that regulation.[37]

Since both parties to the appeal have questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[38] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made. The Board notes that because both parties have indicated the same information, and have had an opportunity to respond, the Board finds that the parties have had an adequate opportunity to submit factual evidence and legal arguments on this issue.

The regulation at 42 C.F.R. § 413.24(j)(3) provides:

> ***Procedures for determining whether there is an appropriate cost report claim***. Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:
>
> (i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;
>
> (ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;

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[37] EJR Request at 17-21 (citing and discussing *Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) and *Banner Heart Hosp. v. Burwell,* 201 F. Supp. 3d 131 (D.D.C. 2016) to support the assertion that the Board has jurisdiction over the Provider's appeal because the Medicare statute at 42 U.S.C. § 1395oo entitles the Provider to appeal a legal challenge to a Medicare regulation without including a protest item on the Medicare cost report, notwithstanding the 2008 protest item regulation, and arguing that the court's reasoning in those two decisions applies equally to the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j)).

[38] 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."

> (iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

Applying that regulation here, the cost report that the Provider submitted, and was accepted by, the contractor will be referenced to make this determination, as none of the exceptions in the regulation apply to the circumstances of this case.[39] Specifically, there is no evidence in the administrative record that the Provider submitted an amended cost report, or that the contractor reopened the final contractor determination.[40] Further, there were no contractor adjustments with respect to specific cost report claims for the DGME fellows penalty issue on appeal.[41] Indeed, in the appeal request, the Provider concedes these facts.

Based on the above and pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that it is undisputed that the Provider failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2) in this case.[42]

3. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) & 405.1873

The Provider plainly admits in its appeal request that it did not protest the DGME fellows issue on its cost reports in compliance with what it describes in its EJR request as the "self-disallowance regulation" at 42 C.F.R. § 413.24(j) which is entitled "Substantive reimbursement requirement of an appropriate cost report claim" and specifies that "[i]n order to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report . . . must include an appropriate claim for the specific item, by either – (i) Claiming full reimbursement in the provider's cost report for the specific item . . . ; or (ii) Self-disallowing the specific item in the provider's cost report . . . ." The Provider also states in the EJR request that § 413.24(j) as well as and the related regulation at 42 C.F.R. § 405.1873 are invalid. Accordingly, the Provider's Representative simultaneously requested EJR over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 in addition to the DGME fellows issue

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[39] *See* 42 C.F.R. § 413.24(j)(3).
[40] *See id.* at § 413.24(j)(3)(i), (iii).
[41] *See id.* at § 413.24(j)(3)(ii). On review of the Provider's Worksheet E-4 for the period at issue, the Provider did not self-disallow the specific item or issue under appeal. *See* Exh. P-12; *see also Provider Reimbursement Manual*, Pt. II, ch. 40, § 1034 (June 30, 2015) ("Use this worksheet to calculate each program's payment (i.e., titles XVIII, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct graduate medical cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers."
[42] The Board recognizes that, on June 28, 2022, the Representative filed a challenge to the regulations at 42 C.F.R. §§ 405.1873 and 413.24(j)

(discussed more fully, below).[43] The Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the DGME fellows issue discussed more fully, below).[44]

In the EJR request, the Provider argues that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo.[45] They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[46] The Provider recounts how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016).[47] They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[48]

With regard to the Board's jurisdiction, the Provider points to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[49] Further, the Providers argue that because the MAC argues that the substantive claim regulatory provisions prevent the Provider from receiving additional reimbursement for FTEs removed due to the DGME fellows penalty regulation, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the DGME penalty regulation and is integral to the resolution of the DGME penalty issue.[50]

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Provider's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue. Since there is no factual dispute regarding the Provider's lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Provider's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, 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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

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[43] Provider's EJR Request at 7-8, 17-21.
[44] Providers' (Second) Petition for EJR at 1-2, 5-9 (June 28, 2022). While the Provider did not specifically apply the EJR request in its June 28, 2022 filing to this case, the Board finds that the briefing therein was intended to apply in those cases where the Board finds that § 405.1873(a) has been triggered (as in this case).
[45] *Id.* at 6.
[46] *Id.*
[47] *Id.* at 6-8.
[48] *Id.* at 8-9.
[49] *Id.* at 11.
[50] *Id.*

C. Board's Analysis of the Appealed Issue

The Provider asserts 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 Provider asserts 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.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [51]

Accordingly, the Board set out to confirm the Provider's 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.[52] 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.[53] 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,

[51] EJR Request at 10-15.
[52] *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.)).
[53] 66 Fed. Reg. at 39894 (emphasis added).

> 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].[54]

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.[55] 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."[56] 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[57] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[58]

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:

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[54] (Emphasis added.)

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

[56] *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.)).

[57] 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.

[58] 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.

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

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 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 this case.

Board's Decision Regarding the EJR Request

The Board finds that:

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

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

3) 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;

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and*** whether the regulation at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the legal questions in Finding #5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in this appeal, the Board hereby closes it

and removes it from the Board's docket. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

7/18/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Leslie Goldsmith, Esq.
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Washington, D.C. 20004

RE: ***EJR Determination***
Bass, Berry & Sims, PLC CY 2019 DGME Penalty to FTE Count Group
Case No. 22-1082G

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 2, 2022 request for expedited judicial review ("EJR") in the above-referenced individual appeal. The decision of the Board is set forth below.

Issue in Dispute

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

> Whether the Medicare Administrative Contractor ("MAC") must correct its determinations of each Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency periods ("IRPs") used for determining payments for direct graduate medical education ("DGME")
>
> ***
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, 42 U.S.C. § 1395ww(h)(4)(C). The Provider disputes the computation of the current, prior and penultimate weighted DGME FTEs and the FTE cap. CMS's implementation of the cap and weighting factors is contrary to the statute, because it imposes on the Provider a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Provider from claiming FTEs up to its full FTE caps. See 42 C.F.R. § 413.79(c)(2). The

> regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Provider's DGME payments consistent with the statute so that the DGME caps are set at the number of FTE residents that the Provider trained in its most recent cost reporting period ending on or before December 31, 1996, and residents beyond the IRPs are weighted at no more than 0.5. The Provider self-disallowed the amount at issue, because the MAC was bound to deny payment pursuant to the regulation at 42 C.F.R. § 413.79(c)(2), and the Provider challenges that regulation. See CMS-1727-R.

Background

The Medicare statute requires the Secretary[1] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[2] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[3]

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.[4]

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 . . .

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

> (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[5] ("*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")[6] 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.[7]

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.[8] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"),

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[5] "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).

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

[7] 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.

[8] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents **over** the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.
>
> • *Multiply the ratio determined above by* the weighted FTE count for those residents for the cost reporting period. Add the weighted count of residents in dentistry and podiatry to determine the weighted FTEs for the cost reporting period. This methodology should be used for purposes of determining payment for cost reporting periods beginning on or after October 1, 1997. . . .
>
> For example, if the hospital's FTE count of residents in its cost reporting period ending December 31, 1996 is 100 residents before application of the initial residency weighting factors and the hospital's number of residents for its December 31, 1990 cost reporting period is 110 FTE residents, the ratio of residents in the two cost reporting periods equals 100/110. If the hospital's weighted FTE count is 100 FTE residents in the December 31, 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.[9]

[9] 62 Fed. Reg. at 46005 (emphasis added).

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[10] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[11]

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).[12] 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

[10] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[11] *Id.* at 39894 (emphasis added).
[12] *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."

> 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.[13]

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.[14]

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.[15]

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

The Providers' Position

The Providers are requesting the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2) which implements the DGME cap on full-time equivalent ("FTE") residents and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[16] The Providers explain that they are teaching hospitals that receive DGME payments, and that during the cost year in dispute, their unweighted FTE count exceeded it FTE cap. They also trained fellows and other residents who were beyond their initial residency period ("IRP").[17]

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[13] 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.
[14] 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.")
[15] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[16] Providers' Petition for Expedited Judicial Review at 1 (June 2, 2022) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request").
[17] *Id.* at 8-9.

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[18] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[19] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[20]

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

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

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion. Since, the Board lacks the authority to grant the relief sought, the request for EJR should be granted.

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1) (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. Board review of 30- Day Period Commencement

In a letter to the parties on June 30, 2022, the Board noted that it has full power and authority to make rules and establish procedures which are necessary or appropriate to conduct its affairs.[21] Consistent with this authority, the Board's Rules are general instructions and the Board has the

[18] 42 U.S.C. § 1395ww(h)(4)(F)(i).
[19] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[20] *Id.* at §1395(h)(4)(F)(i).
[21] 42 U.S.C. § 1395oo(e). *See also* 42 C.F.R. §§ 405.1868(a), (b)(3), (c); 405.1853(b)(3), (c)(3)(i).

authority and flexibility to set and amend its own filing deadlines on a case-specific basis or take other remedial action.

Pursuant to Board Rule 20, if all the participants in a fully- formed group are populated under the Issues/Providers Tab in OH CDMS, then within (60) sixty days of the full formation of the group, the group representative ***must file a statement certifying*** that the group is fully populated in OH CDMS ***with the relevant supporting jurisdictional documentation***. On June 2, 2022, the Providers certified that the group was fully formed however did ***not*** submit the requisite Certification of Full Population until June 24, 2022. The Board found that, until the certification was submitted on June 24,2022, the EJR request was, in fact, fatally defective under Board Rule 42.3. However, the Providers cured this fatal defect by filing the Certification on June 24, 2022, notifying the Board and Medicare Contractor that the group was now ready for jurisdictional review.

The Board had determined the 30-day period commenced on June 24, 2022 after the Providers submitted its Certification. Therefore, the Board is now able to proceed with the Provider's Request for Expedited Judicial Review.

B. Board Jurisdiction

On June 23, 2022, the Medicare Contractor filed an initial jurisdictional review of the group appeal. The MAC explains that St. Luke's Hospital (39-0049) filed its appeal request pursuant to Rule 7.4. "Failure to Timely Issue Final Determination" and contends that the appeal request does not appear to be received by the Board timely and thus does not appear to be timely tiled in accordance 42 C.F.R. 405.1835(a)(3). The MAC indicates that in accordance with Board Rule 22, upon full formation of the group and receipt of the final Schedule of Providers, the MAC will review if the issue is suitable for group appeal and whether jurisdictional impediments exist.

On June 23, 2022, the Providers' Group Representative filed a response to the MAC's Response Letter. The Group Representative argues St. Luke's Hospital's appeal was based on the MAC's failure to timely issue a final determination of the Provider's amended cost report for FYE 6/30/2019, which was timely filed. Pursuant to 42 C.F.R. § 405.1835(c)(1), the MAC has 12 months from the filing date to issue a determination and if not, a provider has 180 days after the 12-month period to file its appeal. The Group Representative argues that the supporting documents filed with the appeal reflect the case was filed timely within the 180-day filing period.

The Board finds that St. Lukes' appealed within 180 days of the one-year deadline from which the MAC received the amended (accepted) cost report. Therefore, it timely filed from the failure to timely issue a final determination. The Board similarly finds that it has jurisdiction over the other participant in the group, Keck Hospital of USC, as it was timely filed. Similarly, no statute or regulation precludes administrative and/or judicial review of the common issue for this group and, as such, the Board has substantive jurisdiction. Finally, the Providers' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group

appeal.[22] Based on the above, the Board finds that it has jurisdiction over the two providers within this appeal.

C. 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

In this appeal both providers have cost reports beginning after January 1, 2016 and are subject to the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[23] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[24] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[25] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) if a party to the appeal questions whether there was an appropriate claim made.[26] In this case, although all of the participants in the group are subject to § 413.24(j), the Medicare Contractor has not filed a Substantive Claim Challenge.

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

D. Board's Analysis of the Appealed Issue

The Providers assert` that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Provider asserts that § 413.79(c)(2)(iii) states the

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[22] *See* 42 C.F.R. § 405.1837.
[23] 42 C.F.R. § 413.24(j) (entitled "Substantive reimbursement requirement of an appropriate cost report claim"). *See also* 42 C.F.R. § 405.1873 (entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim").
[24] (Emphasis added.)
[25] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[26] *See* 42 C.F.R. § 405.1873(a),

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 Provider presents 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:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [27]

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.[28] 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.[29] 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

[27] EJR Request at 4.
[28] *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.)).
[29] 66 Fed. Reg. at 39894 (emphasis added).

> 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].[30]

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.[31] 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."[32] 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[33] (*i.e.*, ratios) using variables a, b, c, and d:

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

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.[34]

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:

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

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

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 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.

Board's Decision Regarding the EJR Request

The Board finds that:

1) The 30- day commencement period began after the Providers submitted its Certification of Full Population on June 24, 2022.

2) It has jurisdiction over both the DGME Penalty Issue for the subject year and that the Providers in this appeal are entitled to a hearing before the Board;

3) 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;

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

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

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the DGME Penalty issue and the subject years.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. The Board's jurisdictional determination is subject to review under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. § 405.1875 and 405.1877 upon final disposition of the appeal. As there are no issues remaining in these appeals, the Board hereby closes them 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

FOR THE BOARD:

7/18/2022

X Clayton J. Nix

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

cc: Lorraine Frewert, Noridian Healthcare Solutions (J-E)
Wilson Leong, FSS

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RE: ***Jurisdictional Decision* – SSI Realignment**
Cleveland Clinic 2008 SSI Fraction Medicare Advantage Days CIRP Group
Case No. 13-1824GC

Dear Ms. Goron and Ms. Cummings:

The Provider Reimbursement Review Board ("PRRB" or "Board") reviewed the jurisdictional documentation in the common issue related party ("CIRP") group in Case No. 13-1824GC. The Board's decision is set forth below.

Background

The group appeal request was filed on April 30, 2013. On May 22, 2020, the Group Representative requested that CIRP group under Case No. 20-1543GC (*Cleveland Clinic Fdn. CY 2008 DSH SSI Fraction Medicare Managed Care Part C CIRP Group*) be incorporated into Case No. 13-1824GC. The representative noted that when the group appeal was originally formed, they were unaware that another existing CIRP Group under Case No. 13-1824GC existed for the same health system, cost year, and issue.[1] The Board granted the request, and Case No. 20-1543GC was incorporated into Case No. 13-1824GC and subsequently closed on May 29, 2020.

The group under Case No. 13-1824GC currently includes a participant that has appealed from a revised NPR that was issued subsequent to its request for SSI realignment:[2]

- Provider No. 36-0077 – Fairview Hospital (FYE 12/31/2008)
  - Adj. No 1: "To update the SSI% in accordance with CMS' SSI realignment calculation."

Notably, the provider requested a reopening to realign its SSI percentage on March 2, 2016.[3]

[1] Request to Incorporate Group Appeals (May 22, 2020), PRRB Case nos. 20-1543GC, 13-1824GC.
[2] This is the sole provider that was added from the incorporation of PRRB Case No. 20-1543GC.
[3] *See* Notice of Intent to Reopen Cost Report (Mar. 3, 2016), PRRB Case No. 20-1543GC.

Board's Analysis and Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2017), a provider has a right to a hearing before the Board with respect to specific items claimed on a timely filed cost report if: (1) it is dissatisfied with the final determination of the Medicare contractor; (2) the amount in controversy is $10,000 or more ($50,000 for a group); and (3) the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Code of Federal Regulations provides for an opportunity for a reopening and revised NPR at 42 C.F.R. § 405.1885 (2017), 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 (2017)[4] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or contractor determination or a decision by a reviewing entity after the determination or decision is reopened as provided in §405.1885 of this subpart, the revision must be considered a separate and distinct determination or decision to which the provisions of §§ 405.1811, 405.1834, 405.1835, 405.1837, 405.1875, 405.1877 and 405.1885 of this subpart are applicable.
>
> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

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,

[4] *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).

> 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)).[5]

As described below, the Board finds that it does not have jurisdiction over the participant that filed from a revised NPR, because the revised NPR was issued as a result of the Providers' SSI Realignment request, and did not make adjustments related to the Part C days issue.

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[.]"[6] The reopening in this case was a result of the Provider's request to realign their SSI percentage from the federal fiscal year end to their individual cost reporting fiscal year end. The audit adjustments associated with the revised NPR under appeal clearly revised the SSI percentage in order to realign it from a federal fiscal year to the provider's respective fiscal year. The Board has consistently found that it does not have jurisdiction over revised NPRs that were issued as a result of a provider's request for realignment of its SSI percentage.

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

[5] (Emphasis added.)
[6] 42 C.F.R. § 405.1889(b)(1).

> (iii) Divides the number determined under paragraph (b)(2)(ii) of this section by the total number of days that -
>
> (A) Are associated with discharges that occur during that period; and
>
> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[7]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[8] 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***."[9]

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*

[7] (Emphasis added.)
[8] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[9] (Emphasis added.)

> *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."[10]

Accordingly, the realignment process does not change any of the data underlying the realigned SSI fraction (*e.g*., Part C days or 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 order to effectuate a realignment (*i.e*., realigning the SSI fraction from the federal fiscal year to the provider's fiscal year). Indeed, as noted in the second Federal Register excerpt, CMS' stated realignment policy is that the provider "must accept" the realigned SSI percentage.

In other words, the determination was only being reopened to include realigned SSI percentages. Since the only matters specifically revised in the RNPR was the adjustment to realign the SSI percentage from the federal fiscal year to the provider's fiscal year, the Board does not have jurisdiction over the RNPR appeal of the DSH Part C days issue. In making this ruling, the Board notes that its application of 42 C.F.R. § 405.1889(b) has been upheld by courts on review.[11]

In conclusion, the Board dismisses, Provider No. 36-0077 – Fairview Hospital (FYE 12/31/2008), from Case No. 13-1824GC, because they do not have the right to appeal the revised NPR at issue under 42 C.F.R. § 405.1889 for the DSH Part C days issue. The Board notes that Fairview Hospital (FYE 12/31/2008) remains pending as the Provider has also appealed from its original NPR. The remaining providers in the case, including Fairview Hospital's appeal from its original NPR, will be remanded pursuant to CMS Ruling 1739-R under separate cover.[12]

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

Board Members Participating:

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

For the Board:

7/18/2022

X Clayton J. Nix

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

cc: Wilson Leong, Federal Specialized Services

[10] (Emphasis added.)
[11] *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).
[12] Please note that the same provider, 36-0077, has an original NPR that is still under appeal, for the same fiscal year.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Northwell Health CY 2017 Direct Grad. Med. Ed. Penalty to FTE Count CIRP Grp
Case No. 22-0889GC

Dear Ms. Goldsmith:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' April 8, 2022 request for expedited judicial review ("EJR") in connection with the above-captioned common issue related party ("CIRP") group.[1] On April 27, 2022, the Board granted Federal Specialized Services ("FSS") an extension of time to respond to the EJR request. On June 20, 2022, FSS filed a substantive claim challenge for one of the two Providers in this CIRP group appeal, namely Long Island Jewish Medical Center, Provider No. 33-0195. On June 28, 2022, the Group Representative filed a response for the two Providers that included a second EJR request on the validity of the substantive claim regulations. The decision of the Board on these two EJR reqeusts is set forth below.

Issue in Dispute

The issue for which EJR was initially requested is:

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

Background

The Medicare statute requires the Secretary[3] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical

[1] The EJR request was for a total of seven cases. The seven remaining cases, 22-0605GC, 22-0962GC, 22-0839GC, 22-0769GC, 22-0846, and 22-0918, will be addressed in separate determination letters.
[2] Providers' EJR Request at 1 (citing 42 U.S.C. § 1395ww(h)(4)(F)).
[3] of the Department of Health and Human Services.

education or "DGME"). [4] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[5]

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.[6]

This group appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[7] ("*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")[8] 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 include in its FTE count for DGME payments. For cost

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[4] 42 U.S.C. § 1395ww(h).
[5] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[6] 42 U.S.C. § 1395(h).
[7] "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).
[8] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

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.[9]

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.[10] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[9] 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.
[10] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 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.[11]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[12] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

[11] 62 Fed. Reg. at 46005 (emphasis added).
[12] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> 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.[13]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[14] 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.[15]

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.[16]

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

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[13] *Id.* at 39894 (emphasis added).
[14] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[15] 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.
[16] 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.")

> average of the actual full-time equivalent resident counts for the cost reporting period and the preceding two cost reporting periods.[17]

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 in this group appeal are teaching hospitals that receive DGME payments.[18] During the cost year at issue in this appeal, the Providers' FTE counts exceeded their FTE caps.[19] The Providers are requesting that the Board grant EJR as to the validity of the regulation at 42 C.F.R. § 413.79(c)(2), implementing the DGME cap on FTE residents and the FTE weighting factors.[20] Specifically, the Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2) is contrary to "the statute" because it determines the cap after application of the weighting factors.[21] The Providers explain that the effect of the "unlawful" regulation is to impose on the Providers a weighting factor that results in a reduction of greater than 0.5 for many residents who are beyond the IRP, and it prevents the Providers from claiming their full unweighted FTE caps authorized by statute, which the Providers refer to as the "fellowship penalty." The Providers argue that the calculation of the current, prior-year, and penultimate-year weighted DGME FTEs and the FTE caps is contrary to the statutory provision at 42 U.S.C. § 1395ww(h), and results in the Providers' DGME payments being understated.[22]

Addressing these contentions more fully, the Providers argue that the applicable statute at 42 U.S.C. § 1395ww(h)(4) caps the number of residents that a hospital may claim at the number it trained in cost years ending in 1996, that the weighting factor is 0.50 for residents beyond the IRP, and that the current year FTEs are capped before application of weighting factors.[23] The Providers claim that CMS' regulation at 42 C.F.R. § 413.79(c)(2)(ii)-(iii) is contrary to this statute because it determines a cap after application of the weighting factors to fellows in the current year.[24]

Second, the Providers argue that CMS' weighted FTE cap "prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows[,]" and that two hospitals with identical 1996 FTE caps would be treated differently if one trained even a partial FTE fellow.[25] Finally, the Providers claim "the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute."[26]

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[17] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[18] Provider's Petition for Expedited Judicial Review at 8 (Apr. 8, 2022) (hereinafter "EJR Request").
[19] *Id.*
[20] *Id.* at 1 (citing 42 U.S.C. §§ 1395oo(f)(1); 42 C.F.R. § 405.1842(d))
[21] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)).
[22] *Id.*
[23] *Id.* at 10.
[24] *Id.* at 10-11.
[25] *Id.* at 11-13.
[26] *Id.* at 13.

The Providers allege that, even if CMS' regulation was consistent with the controlling statute, it is arbitrary and capricious because it prevents the provider from reaching its FTE cap and treats similarly situated hospitals differently.[27] Finally, the Providers state that the U.S. District Court for the District of Columbia has already ruled that CMS' regulation is contrary to law.[28]

The Providers explain that some of the Providers in the combined EJR Request expressed dissatisfaction with CMS' regulation by protesting this issue on their cost reports, and others self-disallowed this issue based on the MAC being bound by the regulation at 42 C.F.R. § 413.79(c)(2) and the Providers' challenge to that regulation.[29] The Providers argue that the Board has jurisdiction over the appeals even where there was not a protest item, because the Providers are dissatisfied with final determinations made by MACs as dictated by 42 C.F.R. § 413.79(c)(2), and the Medicare statute at 42 U.S.C. § 1395oo entitles the Providers to appeal a legal challenge to a Medicare regulation without including a protest item on the Medicare cost report.[30]

The Providers argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2) and thus should grant their request for EJR.[31] In sum, the Providers assert that the regulation, 42 C.F.R. § 413.79(c)(2), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

FSS' Substantive Claim Challenge & the Providers' Second EJR Request

On June 20, 2022, FSS filed a substantive claim challenge for one of the two providers at issue, namely Long Island Jewish Medical Center (Provider No. 33-0195), asserting that the Provider did not include an appropriate claim for the disputed issue. FSS argues that pursuant to 42 C.F.R. § 413.24(j), the Provider was required to include an appropriate claim for a specific item in its Medicare cost report in order to receive or potentially qualify for Medicare payment for the specific item. Specifically, FSS argues that the Provider has not claimed reimbursement for the calculation of the weighted FTE counts on its cost report in accordance with Medicare policy nor has the Provider self-disallowed the specific item in its cost report, and none of the exceptions in section 413.24(j)(3)(i)-(iii) apply.

Referring to 42 C.F.R. § 413.24(j)(1)(i), the MAC contends that there is nothing in the record to show where the Provider claimed the disputed items for full reimbursement following a belief that the items comported with Program policy. The Provider did not cite an audit adjustment related to an amount claimed on its cost report stemming from the purported Provider's DGME cap of full-time equivalent residents and the weighting of residents training beyond the initial residency periods. Thus, FSS asserts that the Provider has not claimed reimbursement for the specific issue in its cost report in accordance with Medicare Policy.

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[27] *Id.* at 15.
[28] *Id.* at 15-16.
[29] *Id.* at 17-18.
[30] *Id.* at 18, *citing Bethesda Hosp. Ass'n v. Bowen,* 485 U.S. 399 (1988) and *Banner Heart Hosp. v. Burwell,* 201 F. Supp. 3d 131 (D.D.C. 2016).
[31] *Id.* at 21.

Referring to 42 C.F.R. § 413.24(j)(1)(ii) and (j)(2), the MAC notes that the Provider filed its FYE 12/31/2017 Medicare cost report identifying $5,248,061 Part A Protested Amounts. Along with its cost report for the FYE 12/31/2017, the Provider submitted a Summary of Protested Amounts that also reflected a total of $5,248,061 in Part A Protested Amounts. A review of the Summary of Protested Amounts reveals that the Provider did not establish a self-disallowed item for the calculation of the weighted FTE counts in its FYE 12/31/2017 cost report. Thus, FSS asserts that the Provider did not properly protest the specific item as described at 42 C.F.R. § 413.24(j)(2).

On June 28, 2022, the Group Representative responded to FSS' substantive claim challenge by filing a second petition for EJR on the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 for the Providers in this case. Specifically, the Group Representative explained that the Providers' appeal of 42 C.F.R. § 413.79(c)(2)(iii) now encompasses §§ 413.24(j) and 405.1873, which "unlawfully constrain the authority of the Board and the federal courts to order additional reimbursement withheld due to the invalid DGME regulation."

In the second EJR request, the Group Representative acknowledges that one of the Providers, Long Island Jewish Medical Center, Provider No. 33-0195, did ***not*** file a protest item to 42 C.F.R. § 413.79(c)(2)(iii) and instead self-disallowed this issue based on the MAC being bound by the regulation at 42 C.F.R. § 413.79(c)(2). The Providers contend that the protest item requirement of 42 C.F.R. §§ 413.24(j) and 405.1873 is inconsistent with the Medicare statute and invalid, and does not prevent payment resulting from the Providers' challenge to 42 C.F.R. § 413.79(c)(2)(iii). The Group Representative argues that the EJR request should be granted as to these regulations because the Board has jurisdiction over this appeal and because the Board lacks authority to decide the Providers' challenge to a regulation promulgated by the Secretary of Health and Human Services.

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) (2022), the Board is required to grant an EJR request if it determines that: (i) the Board has jurisdiction to conduct a hearing on the specific matter at issue; and (ii) the Board lacks the authority to decide a specific legal question relevant to the specific matter at issue because the legal question is a challenge either to the constitutionality of a provision of a statute or to the substantive or procedural validity of a regulation or CMS Ruling.

A. Jurisdiction

The Providers' appeals were timely filed and no jurisdictional impediments have been identified (*e.g.*, there is no statute or regulation that precludes administrative and/or judicial review of the group's common issue). The Providers' documentation shows that the estimated amount in controversy in this group appeal exceeds $50,000, as required for a group appeal.[32] Based on the above, the Board finds that it has jurisdiction over this group appeal.

[32] *See* 42 C.F.R. § 405.1837.

B. Board Review of Compliance with the Reimbursement Requirement of an Appropriate Cost Report Claim Pursuant to 42 C.F.R. §§ 405.1873 and 413.24(j) for Cost Reports Beginning on or After January 1, 2016

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[33]

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

[33] (Bold and underline emphasis added.)

> (a) *General*. In order to receive or potentially receive reimbursement for a specific item, the provider **must include in its cost report an appropriate claim for the specific item** (as prescribed in § 413.24(j) of this chapter). If the provider files an appeal to the Board seeking reimbursement for the specific item and any party to such appeal questions whether the provider's cost report included an appropriate claim for the specific item, the Board must address such question in accordance with the procedures set forth in this section.
>
> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .[34]

These regulations are applicable to the cost reporting period for the two Providers in this group case, which both begin on January 1, 2017, and end on December 31, 2017.

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

As explained above, at issue in this group appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an

[34] (Bold and underline emphasis added.)

appropriate cost report claim.[35] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[36] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[37] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument) ***if*** a party to the appeal questions whether there was an appropriate claim made.[38] On June 20, 2022, the Medicare Contractor filed a Substantive Claim Challenge for one of the Providers, Long Island Jewish Medical Center, and asserted that an appropriate claim was not made by this particular Provider. The Provider filed a response to that Challenge and conceded that it did not protest the specific item under appeal but rather simply self-disallowed the specific item under appeal.[39]

Since a party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[40] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made by Long Island Jewish Medical Center. However, the Provider has filed its response and concedes that it did not comply with 413.24(j).[41]

Based on the above, it is clear that the parties have had an adequate opportunity to submit factual evidence and legal arguments on this issue. Further, pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that Long Island Jewish Medical Center failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2), and notes that this is undisputed as the Provider/Group Representative has acknowledged this fact.

In addition, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made by the other Provider, Staten Island University Hospital,[42] the Board

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[35] 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").
[36] (Emphasis added.)
[37] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[38] *See* 42 C.F.R. § 405.1873(a).
[39] Provider's Response and EJR Request at 6, 9 (June 28, 2022).
[40] 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."
[41] Regardless, there is no evidence in the administrative record that the Provider protested the DGME fellows penalty issue on appeal or that the Provider submitted an amended cost report, or that the contractor reopened the final contractor determination. Further, there is no indication that the contractor adjusted the Provider's cost report with respect to specific cost report claims for the DGME fellows penalty issue on appeal. *See id.* at § 413.24(j)(3)(ii).
[42] Board Rule 10.2 provides that "[i]f 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."

finds that there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made for this particular Provider. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for this Provider. Accordingly, the Board will proceed to rule on the EJR requests pursuant to 42 C.F.R. § 405.1873(d).

C. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873

While Long Island Jewish Medical Center, Provider No. 33-0195, admits that it did not protest the DGME fellows issue on its cost report, the Provider asserts that the self-disallowance regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are invalid insofar as these regulations would limit the Board's authority to order payment to providers that have not claimed a particular cost on their cost report as an allowable cost or as a protested amount. The Group Representative requested a second EJR in this particular case over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (in addition to the DGME fellows issue discussed more fully, below).[43]

In the EJR request, the Providers argue that the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 contravene the Board's authority set forth in 42 U.S.C. § 1395oo.[44] They note that nowhere in the statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[45] The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp. 3d 131, 140 (2016).[46] They argue that the 2016 self-disallowance regulation at 42 C.F.R. § 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[47]

With regard to the Board's jurisdiction, the Providers point to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[48] The Providers note that while the validity of these regulatory provisions was not at issue when the Providers filed their appeal, the MAC raised this issue in its Substantive Claim Letter, and the Board's rules entitle the Providers to respond, including in the context of an EJR filing, citing Board Rule 44.5.2.[49] Further, the Providers argue that because the MAC argues that the substantive claim regulatory provisions prevent Long Island Jewish Medical Center from receiving additional reimbursement for FTEs removed due to the DGME fellows penalty regulation, the validity of these substantive claim regulatory provisions stems from the Providers' appeal of the DGME penalty regulation and is integral to the resolution of the DGME penalty issue.[50]

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[43] Providers' (Second) Petition for EJR at 1-2, 5-9 (June 28, 2022).
[44] *Id.* at 6.
[45] *Id.*
[46] *Id.* at 6-8.
[47] *Id.* at 8-9.
[48] *Id.* at 11.
[49] *Id.*
[50] *Id.*

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the Provider's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal.[51] Since there is no factual dispute regarding the Provider's lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of the Provider's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, 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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

D. Board's Analysis of the Appealed Issue in the Initial EJR Request

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.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [52]

Accordingly, the Board sets 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.[53] As such, the equation would logically appear to be a

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[51] The Board recognizes that this question relates only to Long Island Jewish Medical Center and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, as a procedural matter per § 405.1873(a), a party question's the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to Long Island Jewish Medical Center.

[52] EJR Request at 10-15.

[53] *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.[54] 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].[55]

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.[56] 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."[57] 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[58] (*i.e.*, ratios) using variables a, b, c, and d:

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

[54] 66 Fed. Reg. at 39894 (emphasis added).
[55] (Emphasis added.)
[56] *See* 62 Fed. Reg. at 46005 (emphasis added).
[57] *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.)).
[58] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[59]

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:

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

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 this issue.

Board's Decision Regarding the EJR Requests

The Board finds that:

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

[59] 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.

2) The Providers appealed cost reporting periods beginning after January 1, 2016 but one of the participants in this group, Long Island Jewish Medical Center (Prov. No. 33-0195), failed to include "an appropriate claim for the specific item" that is the subject of the appeal, as required under 42 C.F.R. § 413.24(j);

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

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, in connection with Long Island Jewish Medical Center, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[60]

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2)(iii) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the DGME Penalty issue and the subject year. The Board also finds that the question of the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for this issue 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 this group appeal, the Board hereby closes it and removes it 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:

7/18/2022

X Clayton J. Nix

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

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

[60] *See supra* note 51.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: *EJR Determination*
18-0479GC: *Mount Sinai Health System 2013 DGME Fellows CIRP Group*; 1/12/2018
18-0480GC: *Mt. Sinai Health Sys. 2013 DGME Fellows Prior & Penultimate Yrs. CIRP*; 1/12/2018
18-1082GC: *Mount Sinai Health System 2014 DGME Fellows CIRP Group*; 3/15/2018
18-1083GC: *Mt. Sinai Health Sys. 2014 DGME Fellows Prior & Penultimate Yrs. CIRP*; 3/15/2018
18-0481GC: *Mount Sinai Health System 2015 DGME Fellows CIRP Group*; 1/12/2018
18-0482GC: *Mt. Sinai Health Sys. 2015 DGME Fellows Prior & Penultimate Yrs. CIRP*; 1/12/2018

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 23, 2022 consolidated request for expedited judicial review ("EJR") in the above-referenced 6 common issue related party ("CIRP") group appeals. The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. They explain that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP")) and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Providers contend that, in effecting these provisions, CMS created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Providers argue that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Providers also note that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year

[1] Group Issue Statement at 1.
[2] *Id.* at 2-3.
[3] *Id.*

weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

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.

[4] *Id.* at 4.
[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).
[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[10] ("*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")[11] 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.[12]

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.[13] 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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[10] "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).
[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] 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

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

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.[16]

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).[17] 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

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

> residents for the most recent cost reporting period ending on or before December 31, 1996.[18]

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.[19]

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.[20]

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.

Providers' EJR Request

On June 23, 2022, the Providers filed a consolidated EJR Request for six (6) Mount Sinai Health System CIRP group cases noting

> The solitary issue presented in this request for EJR is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).[21]

They note that the Board has previously granted EJR for this issue for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME FTEs violates the Medicare statute.[22] The Providers request the Board grant

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[18] 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.
[19] 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.")
[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] *Id.* at 1-2.
[22] *Id.* at 2 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).

EJR because it has jurisdiction over all of the group appeals. They claim that the amount in controversy in each case exceeds $50,000, that each provider filed a timely appeal, and that each provider is dissatisfied with their reimbursement for the fiscal years at issue. They also argue that, with regard to this dissatisfaction, CMS Ruling 1727-R applies, and they were not required to self-disallow or protest this issue in order to seek reimbursement on appeal. Specifically, the Providers argue that the Medicare Contractors were bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which they believe is unlawful, so claiming the cost would have been futile.[23] The Providers request the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[24]

Medicare Contractor's Position

On June 27, 2022, the Medicare Contractor filed a timely response to the EJR Request asking for sixty (60) days to file its jurisdictional challenges, if any, in these cases. It notes that all six (6) of these group cases were deemed fully formed on June 23, 2022, the same day the EJR request was filed. It also notes that Board Rules 44.6 and 22 give the Medicare Contractors sixty (60) days after receipt of the final Schedule of Providers ("SOPs") to file jurisdictional challenges. Based on these rules, the Medicare Contractor believes it would be appropriate to give it sixty (60) days to review these cases for jurisdictional issues.

Decision of the Board

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

At the outset, the Board notes that the Board Rules require that, if the Medicare contractor opposes an EJR request filed by a group of providers, it must file its response within five (5) business days of the filing of the EJR request.[25] The Medicare Contractor filed a timely request for an extension of time to file jurisdictional challenges. However, the Board hereby denies that request. This denial is based on the limited number of providers in each case, how they were added to the group as participants, and the fact that these cases were fully populated in OH CDMS as certified by the Group Representative on June 23, 2022. In particular, each of these cases involve the same two providers which were *directly added* (as opposed to a transfer from another case) to the case following the issuance of an original NPR.

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[23] *Id.* at 15-16.
[24] *Id.* at 16 (citing 42 C.F.R. § 405.1867).
[25] Board Rule 42.4 (Nov. 2021). A response in this case (filed June 23, 2022) would be due no later than Thursday, June 30, 2022.

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]

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.

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[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.
[28] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[29] 201 F. Supp. 3d 131 (D.D.C. 2016).
[30] *Id.* at 142.

The Board has determined that the Providers in Case Nos. 18-0479GC, 18-0480GC, 18-1082GC, 18-1083GC, 18-0481GC, and 18-0482GC involved with the instant EJR request involve cost report periods which began prior to January 1, 2016 and are governed by CMS Ruling CMS-1727-R, and that, pursuant to Ruling 1727-R, there is jurisdiction over the matter at issue since the Providers are challenging a regulation. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000 in each case, 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 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:

$$\mathrm{WFTE}\left(\frac{\mathrm{UCap}}{\mathrm{UFTE}}\right) = \mathrm{WCap}\ ^{32}$$

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

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[31] *See* 42 C.F.R. § 405.1839.
[32] EJR Request at 4.
[33] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted therein as: "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).

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].[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 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

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[35] (Emphasis added.)
[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.

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:

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

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

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

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the Providers in case numbers 18-0479GC, 18-0480GC, 18-1082GC, 18-1083GC, 18-0481GC, and 18-0482GC 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;

[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.

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 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:

7/18/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Danelle Decker, National Government Services, Inc. (J-K)
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.
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Arcadia, CA 91006

RE: **Denial of EJR Requests & Scheduling Order**

15-1161GC	QRS University of AZ Health 2012 SSI Fraction Dual Eligible Days CIRP
15-1162GC	QRS University of AZ Health 2012 Medicaid Fraction Dual Eligible Days CIRP
21-1367GC	Baptist Health Sys. CY 2010 DSH Dual Eligible Days (SSI/MCD Fraction) CIRP
21-1572GC	Baptist Health Sys. CY 2009 DSH SSI/Medicaid Dual Eligible Days CIRP Group
21-1582GC	Baptist Health Sys. CY 2015 DSH SSI/Medicaid Dual Eligible Days CIRP Group
21-1585GC	Baptist Health Sys. CY 2016 DSH SSI/Medicaid Dual Eligible Days CIRP Group
13-3814GC	Carolinas Healthcare Sys. 2007 DSH Medicare Ratio Dual Eligible Days CIRP
13-3813GC	Carolinas Healthcare Sys. 2007 DSH Medicaid Fraction Dual Eligible Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") reviewed the pending request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals and, on June 28, 2022 notified the parties that supplemental briefings were required related to the EJR Request following the Supreme Court's recent decision in *Becerra v. Empire Health Found*., No. 20-1312 (S. Ct. June 24, 2022). On July 19, 2022, the Providers' group representative, Quality Reimbursement Services ("QRS"), filed its response that confirmed the Providers still intended to pursue EJR and requested additional time to brief and respond to the Board's request for information ("RFI") with an updated EJR request. Set forth below is the Board's determination to deny the EJR requests and its Scheduling Order requiring certain additional information and actions from QRS in these cases.

Issue in Dispute in the EJR Request

The Providers in the above-captioned cases have filed EJR requests to challenge the treatment of certain Part A patient days in the Medicare and Medicaid fractions used to calculate their Disproportionate Share Hospital ("DSH") payments. Specifically, the Providers are challenging the treatment of certain "non-covered" or "exhausted" Part A days, wherein a patient was eligible for Medicaid Part A benefits, but no payments were made by Medicare Part A for a variety of reasons. The Providers have challenged the Secretary's policy (as set forth in the FY 2005 IPPS Final Rule) to include these noncovered days in the Medicare fraction and the resulting continued

exclusion[1] of the subset of those days involving dually eligible patients from the numerator of the Medicaid fraction.

Board's Scheduling Order Issued June 28, 2022

On June 28, 2022, the Board issued a Scheduling Order, requiring a response from QRS within 21 days (*i.e.*, by July 19, 2020). As the previous EJR Request (and any responses thereto) were submitted prior to the Supreme Court's recent ruling in *Empire*, they did not discuss the Supreme Court's resolution of the regulatory dispute at issue. Accordingly, the Board exercised its authority under 42 C.F.R. § 405.1842(e)(3) to require that the Group Representative provide the following to the Board:

1. A case-status update on each of the above-captioned groups and to confirm whether the participants in each of those groups remain committed to pursuing the EJR request;

2. For each case not being pursued, a request for withdrawal.

3. For each case being pursued, to update the EJR request to discuss the impact of *Empire* on the EJR request challenging (whether in whole or in part) the Secretary's policy of including no-pay/exhausted Part A days in the Medicare fraction.[2]

Accordingly, given the import of the *Empire* decision, the Board notified the Providers that failure of the Group Representative to comply with the Scheduling Order and timely file its response (without a Board-approved extension) may result in dismissal of the relevant CIRP groups.

Providers' July 19, 2022 Response

QRS responded on July 19th, stating:

1. The participants remain committed to pursuing the EJR request;

2. There are no withdrawals of cases; and

3. QRS asserts that the Supreme Court's decision in *Empire* held that exhausted days are properly includable in the Medicare Fraction and that "'entitled' and 'eligible' have the same meaning for purposes of the Medicare Fraction" citing to the slip opinion at page 8. Pursuant to *Empire*, QRS states that the Providers intend to submit "updated EJR requests to focus ***on the numerator of the Medicare Fraction***, insofar as only 'paid' days are included there, and not also 'eligible' (a/k/a 'entitled' days)."[3]

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[1] The Secretary's policy in effect prior to the FY 2005 IPPS Final Rule was to exclude no-pay Part A days from both the Medicare fraction and the numerator of the Medicaid fraction. *See* CMS Ruling 1498R-2 at 3 (Apr. 22, 2015).
[2] This information is necessary for the Board to rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii). This is highlighted by the fact that a group appeal may only contain one issue in order for the Board to have jurisdiction over that group) per § 405.1837(a). *See also* discussion at footnotes 13 and 20 in the Board's RFI dated June 28, 2022.
[3] (Emphasis added).

Accordingly, QRS requested an additional 14 days in which to submit the Providers' updated EJR requests.

Discussion and Board Decision

The Board notes that there are 8 CIRP group appeals to which the Board requested additional briefing, and to which the Provider responded. Of the 8 CIRP group appeals, 4 challenged both the Medicaid and Medicare fractions as they relate to the treatment of no-pay Part A days in the DSH calculation. These 4 CIRP group cases relate to the Baptist Health System for the years 2009, 2010, 2015, and 2016:

Medicaid and Medicare fraction
21-1367GC Baptist Health Sys. CY 2010 DSH Dual Eligible Days (SSI/MCD Fraction) CIRP
21-1572GC Baptist Health Sys. CY 2009 DSH SSI/Medicaid Dual Eligible Days CIRP Grp
21-1582GC Baptist Health Sys. CY 2015 DSH SSI/Medicaid Dual Eligible Days CIRP Grp
21-1585GC Baptist Health Sys. CY 2016 DSH SSI/Medicaid Dual Eligible Days CIRP Grp

The remaining 4 appeals consist of 2 appeals specific to the Medicare fraction and 2 related appeals specific to the Medicaid fraction. Specifically, the Carolinas Healthcare System has a set of 2007 CIRP groups for the DSH treatment of no-pay Part A days, one for the Medicare fraction and the other for the Medicaid fraction as it relates to the subset of those days involving dually eligible patients. Similarly, the University of Arizona Health has a set of 2012 CIRP groups for the DSH treatment of no-pay dual eligible days, one for the Medicare fraction and the other for the Medicaid fraction.

Medicaid Only
13-3813GC Carolinas Healthcare Sys. 2007 DSH Medicaid Fraction Dual Eligible Days CIRP
15-1162GC QRS University of AZ Health 2012 Medicaid Fraction Dual Eligible Days CIRP

Medicare Only
13-3814GC Carolinas Healthcare Sys. 2007 DSH Medicare Ratio Dual Eligible Days CIRP
15-1161GC QRS University of AZ Health 2012 SSI Fraction Dual Eligible Days CIRP

QRS' July 19, 2022 response is, at best, incomplete and only asks for additional time to "update the EJR requests to ***focus on*** *the numerator of the Medicare Fraction*, insofar as only 'paid' days are included there, and not also 'eligible' (a/k/a 'entitled' days)." Moreover, it is not lost on the Board that QRS waited until the ***final*** day to request an extension of time to respond to the Board's RFI. As described below, the Board hereby ***denies*** that extension request and ***denies*** the EJR requests.

The Board hereby finds QRS' response failed to brief (as required) the *Empire* decision and it is clear from the response that the Providers are ***not*** pursuing the invalidation of the Secretary policy to count no-pay Part A days in the Medicare fraction as adopted in the FY 2005 IPPS Final Rule (the "No-Pay Part A Policy") and, through that invalidation seeking to have no pay Part days excluded from the Medicare fraction and, to the extent those days involve dually

eligible patients, included in the numerator of the Medicaid fraction. Rather, QRS has represented that there is a new and separate issue in these CIRP groups involving only the numerator of the Medicare fraction. However, QRS ***failed*** to brief that additional issue and again *waited until the* ***final*** *day* to request an extension of time to file what it describes as an updated EJR request.

As a group may contain ***only*** one issue pursuant to 42 C.F.R. § 405.1837(a), the Board must deny the EJR requests submitted in these CIRP groups. To the extent the CIRP groups contain another legal issue, then that issue must be bifurcated and any EJR related to that issue cannot be filed until that bifurcation has been effectuated and a new CIRP group established. Further, since it is clear that QRS is not pursuing the No-Pay Part A Policy (and failed to otherwise timely brief that issue per the Board's RFI), the Board is dismissing that issue as abandoned and pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b).

As QRS has made clear that the new separate issue only pertains to the numerator of the Medicare fraction, the Board hereby dismisses the following 2 CIRP groups that only pertain to the Medicaid fraction as abandoned and pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b) – Case Nos. 13-3813GC (Carolinas Healthcare System 2007 DSH Medicaid Fraction Dual Eligible Days CIRP) and 15-1162GC (University of AZ Health 2012 Medicaid Fraction Dual Eligible Days CIRP). In this regard, the Board notes that QRS' response was silent regarding the Medicaid fraction appeals, and provided ***no*** explanation as to how the further pursuit of "paid" days in the *Medicare* Fraction, could impact the appeals that solely relate to the Medicaid fraction (wherein they sought inclusion of those no-pay Part A days involving dually eligible patients in the numerator of the *Medicaid* fraction).

For the remaining 6 CIRP group appeals under Case Nos. 13-3814GC, 15-1161GC, 21-1367GC, 21-1572GC, 21-1582GC and 21-1585GC, the Board is holding these cases open, until Monday, August 22, 2022, to permit QRS to submit a request for bifurcation of the other issue that it appears to be claiming is in these appeals. Specifically, ***by Monday, August 22, 2022***, QRS must file, in each CIRP group case, a request for bifurcation for any issue it intends to pursue outside of its original challenge to the No-Pay Part A Days Policy (and associated relief in the Medicare and Medicaid fractions) and each bifurcation request must include:

1. Attach a copy of the original group issue statement used to establish the group and explain how this group issue statement includes the issue for which QRS is requesting bifurcation.

2. Explain how the additional issue for which bifurcation is being requested was not otherwise abandoned in the subsequent filings that were made in the CIRP group.

3. Explain how the amount in controversy calculations behind Tab E for ***each*** participant in the final Schedule of Providers ("SoP")[4] sets forth the amount in controversy ***separately***

[4] The final SoP is required to include all documentation establishing the Board's jurisdiction. Accordingly, QRS may ***not*** submit any additional jurisdictional documentation without leave of the Board. In making issuing this RFI,

for: (a) the original challenge to the No-Pay Part A Days Policy; and (b) the separate issue for which bifurcation is being requested. Further, explain how the $50,000 minimum threshold amount in controversy is met for the issue for which bifurcation is being requested. In this regard, the Board directs QRS' attention to 42 C.F.R. § 405.1839(b) 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 <u>not allowed to aggregate claims</u> involving different issues**.
>
> (A) **A group appeal must involve a <u>single</u>** question of fact or **<u>interpretation</u> of law**, regulations, or CMS Ruling that is common to each provider (as described in § 405.1837(a)(2) of this subpart).

4. For ***each*** participant in the CIRP group that was transferred into the CIRP group from another case, explain how that participant included the issue, for which bifurcation is being requested, in its original appeal request. The explanation must be based on the documentation that is already part of the final SoP filed for the case and the Board is not giving QRS leave to submit any additional documentation not part of the final SoP as the final SoP was required to include all relevant jurisdictional documentation required to establish the Board's jurisdiction of over each participant in the group.[5]

The Medicare Contractors must file a response ***by Wednesday, September 21, 2022***.

For each of the 6 remaining CIRP groups, following the later of the passing of the QRS' deadline without a timely submission or the Board ruling on a timely-filed bifurcation request, the Board will close these 6 remaining cases since QRS abandoned the Providers' challenge to the No-Pay Part A Days Policy (and associated relief in the Medicare and Medicaid fractions) and failed to timely brief that issue per the Board's RFI.[6] Again, as group appeals are limited to a single legal issue (*i.e.*, "a ***single*** question. . . or ***interpretation*** of law, regulation, or CMS ruling" per § 405.1837(a)(2)), QRS must wait to submit any EJR request on the issue for which it is requesting bifurcation and may not file that request until the Board has determined if it is appropriate to grant that request ***<u>and</u>*** has established a new CIRP group for that issue.

---

the Board is ***not*** giving QRS leave to submit any additional jurisdictional documentation required to be part of the final SoP.

[5] *See supra* note 4.

[6] In addition, QRS did not file an extension request until the day of the filing deadline and did not have a Board-approved extension. The request also failed to explain why it waited *to the last day* to request and extension.

Finally, be advised that:

1. QRS does ***not*** have leave of the Board to file any additional or supplemental jurisdictional documentation not already part of the final SoP and the Board will ***not*** consider any such documentation at this late stage in the proceedings; and

2. The filing deadlines herein are firm and, as the Scheduling Order is being issued in connection with time sensitive matters, the Board has determined to exempt these deadlines from the Alert 19 suspension of Board-set deadlines.

Accordingly, failure of QRS to timely file its bifurcation requests (without a Board-approved extension) will result in dismissal of these cases (including any issues which may have been eligible for bifurcation). Failure of the Medicare Contractors to file a response will result in the Board issuing written notice to CMS describing the Medicare Contractors' failure and requesting that CMS take appropriate action.

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:

7/22/2022

X Clayton J. Nix

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

cc: John Bloom, Noridian Healthcare Solutions
Geoff Pike, First Coast Service Options
Dana Johnson, Palmetto GBA c/o National Government Services, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Ronald Connelly
Powers, Pyles, Sutter & Verville, PC
1501 M St., NW, 7th Fl.
Washington, DC 20005

RE: *EJR Determination*
Case No. 20-1840GC: *UHHS CY 2017 Miscalculation of DGME FTE Cap and Resident Weights CIRP Group*

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 3, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeal as well as a second EJR filed June 8, 2022, specifically challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[12] The decision of the Board is set forth below.

Issue in Dispute

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

> Brief description of the issue:
>
> Whether the Medicare Administrative Contractor ("MAC") must correct its application of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").
>
> Statement identifying the legal basis for the appeal:
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP,

[1] The EJR request was a consolidated request for a total of 5 cases. The remaining cases will be addressed under separate cover.
[2] On June 22, 2022, the Board issued a scheduling order for the MAC to file jurisdictional and/or substantive claim challenges, which stayed the 30 day deadline to respond to the EJR request. Upon the filing of those challenges, and the Provider's responses, the Board has made jurisdictional and substantive claim findings in this determination and can rule on EJR.

> id. § 1395ww(h)(4)(C). The Providers dispute the computation of the current-year, prior-year, and penultimate-year weighted DGME FTEs, the three-year FTE average, and the FTE cap as applied to the current fiscal year. CMS's regulation at 42 C.F.R. § 413.79(c)(2) implementing the cap and weighting factors is contrary to the statute because it imposes on the Providers a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Providers from claiming FTEs up to its full FTE cap. 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Providers' DGME payment consistent with the statute so that the DGME caps are set at the number of FTE residents that each Provider trained in its most recent cost reporting periods ending on or before December 31, 1996, and residents beyond the IRP are weighted at no more than 0.5.[3]

Background

The Medicare statute requires the Secretary[4] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[5] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[6]

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.[7]

This appeal concerns 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:

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[3] Group Issue Statement.
[4] of the Department of Health and Human Services.
[5] 42 U.S.C. § 1395ww(h).
[6] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[7] 42 U.S.C. § 1395(h).

> (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[8] ("*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")[9] 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.[10]

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."

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[8] "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).

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

[10] 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.

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[11] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[12]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[13] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[14]

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.

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[12] 62 Fed. Reg. at 46005 (emphasis added).
[13] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[14] *Id.* at 39894 (emphasis added).

§ 413.79(c)(2)(iii).[15] 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.[16]

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.[17]

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.[18]

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 request that the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii), which implements the DGME cap on full-time equivalent ("FTE") residents

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[15] *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."
[16] 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.
[17] 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.")
[18] 42 U.S.C. § 1395ww(h)(4)(G)(i).

and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[19] The Providers explain that they are teaching hospitals that receive DGME payments, and that during the cost year in dispute, their unweighted FTE count exceeded the FTE cap. They also trained fellows and other residents who were beyond their initial residency period ("IRP").[20]

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[21] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[22] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[23]

Second, the Providers argue, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.[24]

Third, in some situations, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.[25]

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

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[19] Providers' Consolidated Petition for Expedited Judicial Review at 1 (June 3, 2022) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request")).
[20] *Id.* at 9.
[21] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)(i)).
[22] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[23] EJR Request at 9-10 (citing 42 U.S.C. §1395(h)(4)(F)(i)).
[24] *Id.* at 10-13.
[25] *Id.* at 13.

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. *Jurisdiction*

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes a Notice of Amount of Program Reimbursement ("NPR"), a Revised NPR, or failure to timely issue a final determination;[26]
- 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.[27]

In this CIRP group, there are 2 participants. Both participants timely appealed from NPRs to be directly added to this CIRP group and administrative review of the common issue in this appeal is not precluded by regulation or statute. The claimed amount in controversy in this case exceeds the $50,000 threshold. The Medicare Contractor has not noted any jurisdictional challenges. For these reasons, the Board has determined that it has jurisdiction over these two Providers.

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

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on

[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

> an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[28]

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

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

[28] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
>
> ***
>
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[29]

These regulations are applicable to the cost reporting period of the two participants in this group case. A preliminary position paper has been filed for only the Providers, but both parties have submitted filings with regard to whether the impacted Providers included an appropriate cost report claim for the disputed issue.

[29] (Bold and underline emphasis added.)

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

In this appeal, both providers have cost reports beginning after January 1, 2016 and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[30] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[31] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

Following the Providers' June 3, 2022 EJR Request, and after being granted an extension of time to respond, the Medicare Contractor filed a Substantive Claim Challenge.[32] The Medicare Contractor filed its challenge on June 8, 2022, noting that one of the two providers in the group appeal did not make an appropriate cost report claim for the specific item in dispute (specifically, UHHS Richmond Heights Hospital).

That same day, on June 8, 2022, the Providers' Representative filed its response to the MAC's Substantive Claim Letter, which consisted of a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (discussed more fully, below). It plainly admits that UHHS Richmond Heights Hospital did not protest the DGME fellows issue on its cost report, but also asserts that the protest item requirement of 42 C.F.R. §§ 413.24(j) and 405.1873 is invalid.

Pursuant to 42 C.F.R. § 405.1873(d)(2), and on review of the documentation submitted, the Board finds in its specific findings of facts and conclusions of law that UHHS Richmond Heights Hospital (Prov. No. 36-0075, FYE 12/31/2017) failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) and notes that this point is ***uncontested***.

With regard to the remaining participant in this appeal (UH Cleveland Medical Center), 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

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[30] 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").

[31] (Emphasis added.)

[32] As explained 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."

appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[33] 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.[34] In this case, although all of the participants in the group are subject to § 413.24(j), the Medicare Contractor only filed a Substantive Claim Challenge against one participant as discussed above.

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

In summary, Board review under 42 C.F.R. § 405.1873(b) of compliance with the substantive claim requirements in 42 C.F.R. § 413.24(j) has been triggered only with respect to the participant, UHHS Richmond Heights Hospital. Pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds that UHHS Richmond Heights Hospital failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) as this point is ***uncontested***.

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

As noted above, the Providers' Representative filed a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 as it relates to UHHS Richmond Heights Hospital. The Providers' Representative requests that the Board grant EJR as it relates to 42 C.F.R. §§ 413.24(j) and 405.1873.[35] The Providers' Representative claims that these regulations contravene the Board's authority set forth in 42 U.S.C. § 1395oo. He notes that nowhere in that statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[36] The Providers' Representative recounts how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp 3d 131, 140

[33] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[34] *See* 42 C.F.R. § 405.1873(a),
[35] Providers' Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873, 1-2 (June 8, 2022).
[36] *Id.* at 5-6.

(2016). He argues that the 2016 self-disallowance regulation at 42 C.F.R. 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[37]

With regard to the Board's jurisdiction, the Providers' Representative points to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[38]

The Medicare Contractor has not filed a response to this EJR Request and the time for doing so has elapsed.[39]

The Board finds that it ***does*** have jurisdiction over the new EJR challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Including a challenge to these regulations prior to the Medicare Contractor's Substantive Claim Letter would have been premature. As discussed above, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[40] 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.[41] Accordingly, a potential challenge to those regulations only became relevant once the Medicare Contractor filed its Substantive Claim Challenge to trigger Board review of compliance with those regulations.

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the challenge made by UHHS Richmond Heights Hospital regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal.[42] Since there is no factual dispute regarding the Provider's lack of compliance with 42

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[37] *Id.* at 7-9.
[38] *Id.* at 10-11.
[39] PRRB Rule 42.4 (v. 3.1, 2021) ("If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request."). This EJR Request was filed on Wednesday June 8, 2022, so a response would have been due no later than 11:59p.m. (Eastern Time) Wednesday June 15. An extension of time to respond to the EJR requests was granted by the Board, however, no further filings have been submitted and the deadline for doing so was July 18.
[40] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[41] *See* 42 C.F.R. § 405.1873(a).
[42] The Board recognizes that this question relates only to UHHS Richmond Heights Hospital and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered

C.F.R. § 413.24(j), the Board is able to reach consideration of UHHS Richmond Heights Hospital's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, 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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

C. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [43]

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.[44] 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.[45] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap"

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under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to UHHS Richmond Heights Hospital.

[43] EJR Request at 9-12.

[44] *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.)).

[45] 66 Fed. Reg. at 39894 (emphasis added).

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].[46]

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.[47] 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."[48] 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[49] (*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

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[46] (Emphasis added.)
[47] *See* 62 Fed. Reg. at 46005 (emphasis added).
[48] *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.)).
[49] 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.

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.[50]

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 on this issue.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

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

2) It is uncontested that the following participant appealed cost reporting periods beginning after January 1, 2016 but failed to include "an appropriate claim for the specific item"

[50] 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.

that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1) – UHHS Richmond Heights Hospital (Prov. No. 36-0075, FYE 12/31/2017).

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

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, with respect to UHHS Richmond Heights Hospital, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.[51]

Accordingly, the Board finds that the questions in Finding No. 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR. 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 this appeal, the Board hereby closes it and removes it 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:

7/23/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Judith Cummings, CGS Administrators
Wilson Leong, FSS

[51] *See supra* note 42.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Powers Pyles CY 2017 Miscalculation of DGME FTE Cap & Resident Weighting Grp
Case No. 22-0105G

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 6, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeal, as well as a second EJR filed June 24, 2022, specifically challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873.[12] The decision of the Board is set forth below.

Issue in Dispute

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

> Brief description of the issue:
>
> Whether the Medicare Administrative Contractor ("MAC") must correct its application of the Provider's cap of full-time equivalent ("FTE") residents and the weighting of residents training beyond the initial residency period ("IRP") used for determining payments for direct graduate medical education ("DGME").
>
> Statement identifying the legal basis for the appeal:
>
> The Medicare statute caps the number of DGME FTEs that a provider may claim, 42 U.S.C. § 1395ww(h)(4)(F), and also weights DGME FTEs at 0.5 for residents who are beyond the IRP, id. § 1395ww(h)(4)(C). The Providers dispute the computation of

[1] The June 6, 2022 EJR request was a consolidated request for a total of 5 cases. The remaining cases will be addressed under separate cover.
[2] On June 22, 2022, the Board issued a scheduling order for the MAC to file jurisdictional and/or substantive claim challenges, which stayed the 30 day deadline to respond to the EJR request. Upon the filing of those challenges, and the Provider's responses, the Board has made a jurisdictional and substantive claim findings in this determination and can rule on EJR.

> the current-year, prior-year, and penultimate-year weighted DGME FTEs, the three-year FTE average, and the FTE cap as applied to the current fiscal year. CMS's regulation at 42 C.F.R. § 413.79(c)(2) implementing the cap and weighting factors is contrary to the statute because it imposes on the Providers a weighting factor of greater than 0.5 for residents who are beyond the IRP and prevents the Providers from claiming FTEs up to its full FTE cap. 42 C.F.R. § 413.79(c)(2). The regulation at 42 C.F.R. § 413.79(c)(2) is, therefore, invalid, and the MAC must recalculate the Providers' DGME payment consistent with the statute so that the DGME caps are set at the number of FTE residents that each Provider trained in its most recent cost reporting periods ending on or before December 31, 1996, and residents beyond the IRP are weighted at 0.5, and residents within the IRP are weighted at 1.0.[3]

Background

The Medicare statute requires the Secretary[4] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[5] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[6]

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.[7]

This appeal concerns 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:

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[3] Group Issue Statement.
[4] of the Department of Health and Human Services.
[5] 42 U.S.C. § 1395ww(h).
[6] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[7] 42 U.S.C. § 1395(h).

> (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[8] ("*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")[9] 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.[10]

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."

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[8] "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).

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

[10] 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.

CMS implemented BBA § 4623, in part, by promulgating regulations at 42 C.F.R. § 413.86(g)(4) to implement the unweighted FTE cap.[11] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

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

[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[12]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[13] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[14]

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.

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[12] 62 Fed. Reg. at 46005 (emphasis added).
[13] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[14] *Id.* at 39894 (emphasis added).

§ 413.79(c)(2)(iii).[15] 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.[16]

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.[17]

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.[18]

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 request that the Board grant EJR over the validity of the regulation at 42 C.F.R. § 413.79(c)(2)(iii), which implements the DGME cap on full-time equivalent ("FTE") residents

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[15] *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."
[16] 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.
[17] 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.")
[18] 42 U.S.C. § 1395ww(h)(4)(G)(i).

and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[19] The Providers explain that they are teaching hospitals that receive DGME payments, and that during the cost year in dispute, their unweighted FTE count exceeded the FTE cap. They also trained fellows and other residents who were beyond their initial residency period ("IRP").[20]

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[21] Instead, a weighted FTE cap is determined for the current year that is based on the ratio of the 1996 unweighted FTE count to the current year unweighted FTE count. The resulting equation, WFTE(UCAP/UFTE) = WCap,[22] is applied to the weighted FTE count in the current year which creates a second FTE cap that is the absolute limit on the number of FTEs that can go into the DGME payment calculation. The Providers contend that the second cap is determined after the application of the weighting factors to fellows in the current year which violates Congress' directive to determine the cap before the application of the weighting factors.[23]

Second, the Providers argue, the weighted FTE cap prevents a hospital from ever reaching its 1996 unweighted FTE cap if it trains any fellows. The Providers explain that the downward impact on the FTE count increases as hospital trains more residents beyond the IRP and the problem increase as a hospital trains more fellows because the methodology amplifies the reduction.[24]

Third, in some situations, the regulation imposes a weighting factor that reduces FTE time by more than 0.5, contrary to the statute, creating a reduction below the unweight FTE cap and the current year FTE count. The Providers point out that the cap was established based on the hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.[25]

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(ii)-(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

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[19] Providers' Consolidated Petition for Expedited Judicial Review at 1 (June 6, 2022) (citing 42 U.S.C. §§ 1395oo(f)(1) & 1395ww(h)(4)(F); 42 C.F.R. § 405.1842(d) (hereinafter "EJR Request")).
[20] *Id.* at 9.
[21] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)(i)).
[22] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[23] EJR Request at 9-10 (citing 42 U.S.C. §1395(h)(4)(F)(i)).
[24] *Id.* at 10-13.
[25] *Id.* at 13.

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. Jurisdiction

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes a Notice of Amount of Program Reimbursement ("NPR"), a Revised NPR, or failure to timely issue a final determination;[26]
- 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.[27]

In this group, there are only 2 participants. Both participants timely appealed from NPRs to be directly added to this group and administrative review of the common issue in this appeal is not precluded by regulation or statute. The claimed amount in controversy in this case exceeds the $50,000 threshold. The Medicare Contractor has not noted any jurisdictional challenges. For these reasons, the Board has determined that it has jurisdiction over these two Providers.

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

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on

[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

> an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item in the provider's cost report, if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), by following the procedures (set forth in paragraph (j)(2) of this section) for properly self-disallowing the specific item in the provider's cost report as a protested amount.
>
> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, **explaining** why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) **and describing** how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[28]

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

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

[28] (Bold and underline emphasis added.)

> (b) *Summary of Procedures*.
> ***
> (2) Limits on Board actions. The Board's specific findings of fact and conclusions of law (pursuant to paragraph (b)(1) of this section) **must not be invoked or relied on by the Board as a basis to deny, or decline to exercise, jurisdiction** over a specific item or take any other of the actions specified in paragraph (c) of this section. . . .
>
> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
>
> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .
>
> (e) *Two other types of Board decisions that must not include the Board's factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> (1) Board jurisdictional dismissal decision. **If the Board issues a jurisdictional dismissal decision** regarding the specific item under appeal (pursuant to § 405.1840(c)), **the Board's specific findings of fact and conclusions of law** (in accordance with paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must not be included in such jurisdictional dismissal decision**.[29]

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

[29] (Bold and underline emphasis added.)

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

In this appeal, both providers have cost reports beginning after January 1, 2016 and are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[30] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[31] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

Following the Providers' June 6, 2022 EJR Request, and after being granted an extension of time to respond, the Medicare Contractor filed a Substantive Claim Challenge.[32] The Medicare Contractor filed its challenge on June 21, 2021, noting that one of the two providers in the group appeal did not make an appropriate cost report claim for the specific item in dispute (specifically, St. Joseph's Regional Medical Center).

On June 24, 2022, the Providers' Representative filed its response to the MAC's Substantive Claim Letter, which consisted of a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 (discussed more fully, below). It plainly admits that St. Joseph's Regional Medical Center did not protest the DGME fellows issue on its cost report, but also asserts that the protest item requirement of 42 C.F.R. §§ 413.24(j) and 405.1873 is invalid.

Pursuant to 42 C.F.R. § 405.1873(d)(2), and on review of the documentation submitted, the Board finds in its specific findings of facts and conclusions of law that St. Joseph's Regional Medical Center (Prov. No. 31-0019, FYE 12/31/2017) failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) and notes that this point is uncontested.

With regard to the remaining participant in this appeal (Barnes Jewish Hospital), 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

[30] 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").
[31] (Emphasis added.)
[32] As explained 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."

and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[33] 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.[34] In this case, although all of the participants in the group are subject to § 413.24(j), the Medicare Contractor only filed a Substantive Claim Challenge against one participant as discussed above.

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

In summary, Board review under 42 C.F.R. § 405.1873(b) of compliance with the substantive claim requirements in 42 C.F.R. § 413.24(j) has been triggered only with respect to the participant, St. Joseph's Regional Medical Center. Pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds that St. Joseph's Regional Medical Center failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) as this point is ***uncontested***.

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

As noted above, the Providers' Representative filed a separate EJR Request over the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. The Providers' Representative requests that the Board grant EJR as it relates to 42 C.F.R. §§ 413.24(j) and 405.1873.[35] He claims that these regulations contravene the Board's authority set forth in 42 U.S.C. § 1395oo. He notes that nowhere in that statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[36] The Providers' Representative recounts how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp 3d 131, 140 (2016). He argues that the 2016 self-disallowance regulation at 42 C.F.R. 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[37]

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[33] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[34] *See* 42 C.F.R. § 405.1873(a),
[35] Providers' Petition for Expedited Judicial Review of the Validity of 42 C.F.R. §§ 413.24(j) and 405.1873, 1-2 (June 24, 2022).
[36] *Id.* at 5-6.
[37] *Id.* at 8-9.

With regard to the Board's jurisdiction, the Providers' Representative points to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (*on its own motion* or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[38]

The Medicare Contractor has not filed a response to this EJR Request and the time for doing so has elapsed.[39]

The Board finds that it ***does*** have jurisdiction over the new EJR challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Including a challenge to these regulations prior to the Medicare Contractor's Substantive Claim Letter would have been premature. As discussed above, the Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[40] 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.[41] Accordingly, a potential challenge to those regulations only became relevant once the Medicare Contractor filed its Substantive Claim Challenge to trigger Board review of compliance with those regulations.

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the challenge made by St. Joseph's Regional Medical Center regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal.[42] Since there is no factual dispute regarding the Provider's lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of St. Joseph's Regional Medical Center's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, since 42

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[38] *Id.* at 10-11.

[39] PRRB Rule 42.4 (v. 3.1, 2021) ("If the Medicare contractor opposes an EJR request filed by a provider or group of providers, then it must file its response within five (5) business days of the filing of the EJR Request."). This EJR Request was filed on Friday, June 24, 2022, so a response would have been due no later than 11:59p.m. (Eastern Time) Friday, July 1.

[40] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."

[41] *See* 42 C.F.R. § 405.1873(a).

[42] The Board recognizes that this question relates only to St. Joseph's Regional Medical Center and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to St. Joseph's Regional Medical Center.

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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

C. Board's Analysis of the Appealed Issue

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [43]

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.[44] 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.[45] 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

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[43] EJR Request at 9-12.
[44] *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.)).
[45] 66 Fed. Reg. at 39894 (emphasis added).

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].[46]

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.[47] 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."[48] 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[49] (*i.e.*, ratios) using variables a, b, c, and d:

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

On first side of the initial algebraic equation (*i.e.*, the ratio of "a / b") is the following phrase: "the number of FTE residents for that cost reporting period exceeds [the FTE cap or limit]." This phrase (the ***Unweighted FTE Cap*** is to the ***FY's Unweighted FTE Count***) expressed as a ratio ("a/b") is the Unweighted FTE Cap over the FY's Unweighted FTE Count.[50]

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[46] (Emphasis added.)
[47] *See* 62 Fed. Reg. at 46005 (emphasis added).
[48] *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.)).
[49] 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.
[50] 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

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 on this issue.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

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

2) It is uncontested that the following participant appealed cost reporting periods beginning on January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1) – St. Joseph's Regional Medical Center (Prov. No. 31-0019, FYE 12/31/2017).

---

the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, with respect to St. Joseph's Regional Medical Center[51], whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the questions in Finding No. 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR. 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 this appeal, the Board hereby closes it and removes it 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:

7/23/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, FSS

[51] *See supra* note 42.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Mail

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RE: ***EJR Determination***
Beaumont Health 2015 DGME Fellows CIRP Group
Case No. 17-1641GC

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 24, 2022 request for expedited judicial review ("EJR"). The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR is requested is:

> [W]hether 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.[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

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

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]

This appeal concerns the first component of the DGME payment calculation—the resident FTE count.

The Medicare Statute

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

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

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

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

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

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

> equivalent residents for the hospital's most recent cost reporting period ending on or before December 31, 1996.[8]

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

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

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

[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).

> determining direct GME payment is equal to (100/110) [x] 100, or 90.9 FTE residents. . . .
>
> *****
>
> We believe this ***proportional*** *reduction* in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision.[10]

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

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

[10] 62 Fed. Reg. at 46005 (emphasis added).
[11] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[12] *Id.* at 39894 (emphasis added).

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

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

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

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

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

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

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

The Providers' Position

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. This reduction is accomplished by multiplying the weighted FTE count by a fraction consisting of the hospital's FTE cap (numerator) and the

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

[14] 42 C.F.R. §§ 413.79(c)(2)(iii) (2011). The Secretary has not made any changes to § 413.79(c)(2)(iii) since the FY 2005 IPPS final rule.

[15] 77 Fed. Reg. 53258, 53423 (Aug. 31, 2012) (stating that when a hospital trains residents in excess of its cap, "it should report those FTE residents on its cost report regardless of whether or not it is training over its caps.")

[16] 42 U.S.C. § 1395ww(h)(4)(G)(i).

number of unweighted FTEs the hospital reported in that cost reporting year (denominator). This results in the hospital's allowable FTE count.[17]

The Providers point out that the regulation only applies when hospitals report residents in excess of their cap level. Consequently, if a hospital's unweighted FTE count for allopathic and osteopathic residents is less than or equal to its cap, its weighted FTEs are not reduced.[18]

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 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.[19]

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.[20]

Since the FTE counts from the prior and penultimate years were determined in cost reporting periods preceding the payment years under appeal, the Providers note that they may be considered by CMS to be "predicate facts." The Providers point out that CMS has interpreted the three-year limitations period in the reopening regulation at 42 C.F.R. § 405.1885(b)(2)(i) as prohibiting providers from appealing predicate facts in cost report appeals. However, that interpretation was rejected in *Saint Francis Medical Center v. Azar*[21] (*"St. Francis*") which concluded that "42 C.F.R. § 405.1885(b)(2)(i) does not apply to appeals from a fiscal intermediary to the PRRB."[22]

The Providers assert that the Board has jurisdiction over these appeals, as the Providers meet the requirements for jurisdiction under § 1878(a) of the Social Security Act.[23] Moreover, the Providers assert that CMS Ruling 1727-R applies to the period covered by this EJR request and that the Providers have satisfied the five-step analysis required to establish jurisdiction in accordance with the Ruling.[24]

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[17] EJR Request at 1, 8-10.
[18] *Id.* at 8-10.
[19] *Id.* at 11-13.
[20] *Id.* at 1-3, 10. The Board notes that in the EJR request, the Providers also requested bifurcation of the two cases, one for the present year, and one for the prior and penultimate years, if it was found necessary to do so by the Board. The Board does not find it necessary to bifurcate the two cases because the current, prior and penultimate year FTEs are used in the calculation of the formula at 42 C.F.R. § 413.79(c)(2)(iii).
[21] 894 F.3d 290 (D.C. Cir. 2018).
[22] EJR Request at 14 n.38.
[23] *Id.* at 13-14.
[24] *Id.* at 14-15.

In sum, the Providers argue that the Board lacks the authority to decide the validity of CMS' regulation establishing the DGME fellowship penalty implemented through 42 C.F.R. § 413.79(c)(2). Accordingly, the Providers assert that the Board should grant its request for EJR.[25]

The Medicare Contractor has not filed a response to the request for EJR and the time for doing so has elapsed.[26]

Decision of the Board

Pursuant to 42 U.S.C. § 1395oo(f)(1) and the regulations at 42 C.F.R.§ 405.1842(f)(1), 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 Predicate Facts

1. The 2013 Kaiser Case and CMS's Subsequent Revisions to 42 C.F.R. § 405.1885

In 2013, the D.C. Circuit issued its decision in *Kaiser Foundation Hospital v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[27] The *Kaiser* case also involved the statutory cap on indirect medical education (IME) FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates an adjustment to the closed year's reimbursement.[28]

CMS disagreed with the *Kaiser* decision, and in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

[25] *Id.* at 21.
[26] PRRB Rule 42.4 (2021).
[27] *Kaiser Found. Hosps. v. Sebelius,* 708 F.3d 226, 229 (D.C. Cir. 2013).
[28] *Id.* at 229.

> [W]e are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation or other legal provision permitting reauditing, revising, or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose of the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[29]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular issue in *Kaiser* . . . ."[30] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[31] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[32]

2. The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis.* Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[33] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to

[29] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).
[30] *Id.* at 75165.
[31] *Id.*
[32] *Id.* at 74826.
[33] *Saint Francis Med. Ctr. v. Azar,* 894 F.3d 290, 297 (citation omitted).

administrative appeals."[34] The Court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. The Board notes that the regulation was amended in 2020 but only in regard to language relating to mailing and receipt of requests to reopen.[35] However, it is clear from the *Saint Francis* case that the D.C. Circuit did not invalidate 42 C.F.R. § 405.1885 as it applies to predicate facts but rather ***interpreted*** the reopening regulation at 42 C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Further, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the *interpretation* of 42 C.F.R. § 405.1885 (as revised in 2013) because the Provider could bring suit in the D.C. Circuit.[36] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be redetermined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal.*

B. Jurisdiction: 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*"). 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.

On August 21, 2008, new regulations governing the Board were effective. 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

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[34] *Id.* at 294 (emphasis added).
[35] 85 Fed. Reg. 58432, 59019-20 (Sept. 18, 2020).
[36] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

protest. This regulatory requirement was litigated in *Banner Heart Hospital v. Burwell* ("*Banner*"). 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.

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 instant EJR request involves a cost report period which began prior to January 1, 2016 (as it involves the cost report period of calendar year 2015) and is governed by CMS Ruling CMS-1727-R. The Board finds that it has jurisdiction pursuant to this Ruling because the Providers are challenging a regulation and administrative review of that challenge is not precluded by statute or regulation.

In addition, the Providers' jurisdictional documentation shows that all of the Providers in this group case appealed after the Medicare Contractor failed to issue a timely determination pursuant to 42 C.F.R. § 405.1835(c).[37] The Providers filed timely appeals. The amounts in controversy exceed the $50,000 threshold for group appeals.[38]

Based on the above, the Board finds that it has jurisdiction over the above-captioned appeal pursuant to 42 C.F.R. § 405.1837. The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount for each Provider.

C. Board's Analysis of the DGME Fellows Penalty 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.

[37] *See also* 42 C.F.R. § 405.1837(a).
[38] *See* 42 C.F.R. § 405.1837(a)(3).

$$\text{Allowable FTE count} = \text{Weighted FTE Count x} \left(\frac{\text{Unweighted FTE Cap}}{\text{Unweighted FTE Count}}\right)$$ [39]

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

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

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the 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].[42]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted

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[39] EJR Request at 8-13.
[40] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[41] 66 Fed. Reg. at 39894 (emphasis added).
[42] (Emphasis added.)

FTE Cap applicable for the fiscal year.[43] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[44] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[45] (*i.e.*, ratios) using variables a, b, c, and d:

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

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

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

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

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

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

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

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

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

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

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

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 this group case.

Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the DGME Penalty Issue for the subject year and that the Providers in this appeal 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 DGME Penalty issue and the subject year.

The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As there are no issues remaining in this group appeal, the Board hereby closes it and removes it 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:

7/25/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson C. Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

Daniel Hettich, Esq.
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RE: ***EJR Determination***
King & Spalding CY 2016 DGME Fellow Penalty Present Year Group
Case No. 20-0561G

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 1, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeal. The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. They explain that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP") and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Providers contend that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Providers argue that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Providers also note that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

[1] Group Issue Statement at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.
[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

This appeal concerns 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[10] ("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.

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[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[11] 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.[12]

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.[13] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.

[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> • *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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the*

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *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.[16]

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).[17] 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.[18]

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.[19]

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[16] *Id.* at 39894 (emphasis added).
[17] *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."
[18] 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.
[19] 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.")

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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Providers filed an EJR Request for this optional group case noting:

> For all but one of the Providers in this group appeal, there is only one issue presented in this petition for EJR. That issue is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).
>
> . . . .
>
> There is a second issue presented in this petition for EJR for one of the Providers in this group appeal: St. Barnabas Hospital (33-0399). That issue is whether the self-disallowance regulation at 42 C.F.R. § 413.24(j)(1)(ii) is unlawful insofar as it requires providers to self-disallow items in their cost report if they seek payment that they believe "may not be allowable or may not comport with Medicare policy," even if such claims are futile because Medicare Administrative Contractors ("MACs") have no authority to allow them (the "Self-Disallowance" issue). . . . Since St. Barnabas Hospital admittedly did not self-disallow the Fellow Penalty issue in its cost report for the reporting period under appeal and stipulates to that fact, it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful.[21]

They note that the Board has previously granted EJR for ***both*** of these issues for similarly situated providers, and that the District Court for the District of Columbia has held the formula

[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] *Id.* at 1-2.

for counting DGME FTEs violates the Medicare statute.[22] The Providers request the Board grant EJR because it has jurisdiction over all of the group appeals. They claim that the amount in controversy exceeds $50,000, that each provider filed a timely appeal, and that each provider is dissatisfied with their reimbursement for the fiscal years at issue. They also argue that, with regard to this dissatisfaction, either (1) CMS Ruling 1727-R applies;[23] (2) the provider complied with the self-disallowance regulations; or (3) that the self-disallowance regulations are unlawful.[24] Specifically, the Providers argue that the Medicare Contractors were bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which they believe is unlawful, so claiming the cost would have been futile.[25] With regard to St. Barnabas Hospital, they note that this provider did not self-disallow the item under appeal, but argue that the self-disallowance regulations are unlawful. The Providers request the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[26]

Medicare Contractor's Position

On July 7, 2022, the Medicare Contractor filed a response to the EJR request stating:

> The participants in the group case number 20-0561G requested EJR on 7/01/222. The MAC has no objections to the provider's EJR request.

Decision of the Board

A. *Jurisdiction*

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

- They are dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing of each Provider is filed within 180 days of the date of receipt of the final determinations. Providers 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; [27]
- 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.[28]

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[22] *Id.* at 2, 25-26 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).
[23] *Id.* at 23-24.
[24] *Id.* at 17-21.
[25] *Id.* at 22-24.
[26] *Id.* at 27 (citing 42 C.F.R. § 405.1867).
[27] 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).
[28] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

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

1. *Jurisdiction Over the 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*").[29] 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.[30]

On August 21, 2008, new regulations governing the Board were effective.[31] 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*").[32] 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.[33]

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

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[29] 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.).
[30] *Bethesda*, 108 S. Ct. at 1258-59.
[31] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[32] 201 F. Supp. 3d 131 (D.D.C. 2016).
[33] *Id.* at 142.

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 following four providers in this group have fiscal years ending prior to December 31, 2016:

1. University of Iowa Hospital & Clinics (FYE 6/30/2016)
2. University of Kansas Hospital (FYE 6/30/2016)
3. Froedtert Memorial Lutheran Hospital (FYE 6/30/2016)
4. University of Cincinnati Medical Center, LLC (FYE 6/30/2016)

The Board has determined that these four (4) Providers in Case No. 20-0561G involve cost report periods which began prior to January 1, 2016 and are governed by CMS Ruling CMS 1727-R since the Providers are challenging a regulation. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000 in each case, as required for a group appeal.[34] 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.

2. *Jurisdiction Over the Appeals of Cost Report Periods Beginning On or After to January 1, 2016*

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[35] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[36] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Since two (2) providers in this appeal have fiscal years that began on or after January 1, 2016, the claim-specific dissatisfaction requirement is not applicable.

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[34] *See* 42 C.F.R. § 405.1839.
[35] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[36] *Id.* at 70555.

Two (2) participants in this optional group appeal have filed appeals involving fiscal years ending December 31, 2016. Based on its review of the record, the Board finds that each of these participants filed their appeals within 180 days of the issuance of their respective final determinations as required by 42 C.F.R. § 405.1835, that the providers each appealed the issue in this appeal, and that the Board is not precluded by regulation or statute from reviewing the issue in this appeal. Finally, the amount in controversy meets the $50,000 amount in controversy requirement for a group appeal pursuant to 42 C.F.R. § 405.1837(a)(3).

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

1. Regulatory Background

The following two (2) providers have fiscal years ending December 31, 2016 and, as such, are subject to the substantive claim regulations:

1. Houston Methodist Hospital, and
2. St. Barnabas Hospital

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

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

> (2) Self-disallowance procedures. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.

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

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

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

These regulations are applicable to the cost reporting periods under appeal for the two providers noted above, which both have cost reporting periods ending on or after December 31, 2016. The regulation at § 405.1873(b) sets out certain procedures that must be followed in the event a party questions whether the cost report included an appropriate claim for a specific item under appeal. *In such situations where a party raises that question*, the regulation requires the Board to give the parties an adequate opportunity to submit factual evidence and legal arguments regarding whether the provider's cost report included an appropriate claim for the specific item under appeal, and upon receipt of the factual evidence or legal argument (if any), the Board must review the evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the provider's cost report complied with the cost report claim requirements of § 413.24(j).

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[37] with the reimbursement requirement of an appropriate cost report claim for the specific item under appeal (and the supporting factual evidence and legal argument)

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

if a party to the appeal questions whether there was an appropriate claim made.[38] In this optional group case, the Medicare Contractor has failed to file a Substantive Claim Challenge[39] within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers with FYEs December 31, 2016. Indeed, the Medicare Contractor did not raise any substantive claim challenges in its July 7, 2022 response to the Providers' EJR request.

However, as part of its EJR request, the Providers' representative conceded that "St. Barnabas Hospital admittedly did not self-disallow the Fellow Penalty issue in its cost report for the reporting period under appeal and stipulates to that fact, [but] it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful."[40] Accordingly, Board review under 42 C.F.R. § 405.1873(b) has been triggered because a party has questioned St. Barnabas' compliance with § 413.24(j) as described in § 405.1873(a).

The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[41] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

Pursuant to 42 C.F.R. § 405.1873(d)(2), and based on the concession of the Provider,[42] the Board finds in its specific findings of facts and conclusions of law that St. Barnabas Hospital (Prov. No. 33-0399, FYE 12/31/2016) failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1) and notes that this point is uncontested.

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

As noted above, the original EJR Request covering the DGME issue conceded that St. Barnabas Hospital did not self-disallow the DGME issue in its cost report for the reporting period under appeal. It went on, however, to state that "it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful."[43] The Board interprets this statement as a request for EJR over the substantive claim regulations for this provider, in addition to the DGME issue.

With regard to the Board's jurisdiction to grant this request, 42 U.S.C. 1395oo(f)(1) allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (*on its own motion* or at the request of a provider of services as described in the

[38] *See* 42 C.F.R. § 405.1873(a).
[39] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[40] EJR Request at 2.
[41] (Emphasis added.)
[42] *Id.* at 1-2.
[43] *Id.*

following sentence) that it is without authority to decide the question."[44] The Board also notes that the request was plainly stated in the original EJR request, and that the Medicare Contractor's July 7 response to the EJR Request gave a cursory approval to the request in its entirety, without any mention of noncompliance with the substantive claim regulations. Based on the foregoing, the Board finds that it ***does*** have jurisdiction over the new EJR challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873

C. *Board's Analysis of the Appealed Issue*

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

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [45]

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.[46] 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.[47] 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).

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[44] *Id.* at 11.
[45] *Id.* at 4.
[46] *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.)).
[47] 66 Fed. Reg. at 39894 (emphasis added).

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].[48]

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.[49] 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."[50] 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[51] (*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.[52]

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[48] (Emphasis added.)

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

[50] *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.)).

[51] 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.

[52] 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

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.

D. ***Board's Decision Regarding the EJR Request***

The Board finds that:

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

2) The following participant appealed cost reporting periods beginning on January 1, 2016 but failed to include "an appropriate claim for the specific item" that is the subject of the group appeal as required under 42 C.F.R. § 413.24(j)(1): St. Barnabas Hospital (Prov. No. 33-0399, FYE 12/31/2016);

---

the FY's Weighted FTE Count (variable d) over the Weighted FTE Cap (variable c) equals the FY's Unweighted FTE Count (variable b) over the Unweighted FTE Cap (variable a). The unknown variable is still "c" and you would get the same results where rule would then be: If b/a = d/c, then c = (a/b) x d.

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

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, with respect to St. Barnabas Hospital, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the questions in Finding No. 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Case No. 20-0561GC is closed and removed 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:

7/26/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
New Hanover Regional Medical Center (Prov. No. 34-0141, FYE 09/30/2014)
Case No. 22-0681

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's July 1, 2022 request for expedited judicial review ("EJR") in the above-referenced appeal. The decision of the Board is set forth below.

Issue in Dispute

The Provider's issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. It explains that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP")) and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Provider contends that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Provider argues that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Provider also notes that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and

[1] Issues 1, 2 at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.

penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

This appeal concerns 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[10] ("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

[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).
[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

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")[11] 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.[12]

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.[13] 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.

---

[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] 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

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> 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.[16]

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).[17] 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.[18]

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[16] *Id.* at 39894 (emphasis added).
[17] *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."
[18] 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.

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.[19]

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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Provider filed an EJR Request for this individual case noting

> The solitary issue presented in this request for EJR and in issues 1 and 2 of this individual appeal is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).[21]

It notes that the Board has previously granted EJR for this issue for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME FTEs violates the Medicare statute.[22] The Provider requests the Board grant EJR because it has jurisdiction over the appeal. It claims that the amount in controversy exceeds $10,000, that the provider filed a timely appeal, and that the provider is dissatisfied with their reimbursement for the fiscal years at issue. It also argues that, with regard to this dissatisfaction, CMS Ruling 1727-R applies, and it was not required to self-disallow or protest this issue in order to seek

[19] 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.")
[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] EJR Request at 1-2.
[22] *Id.* at 2 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).

reimbursement on appeal. Specifically, the Provider argues that the Medicare Contractor was bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which it believes is unlawful, so claiming the cost would have been futile.[23] The Provider requests the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[24]

Medicare Contractor's Position

The Board Rules require that, if the Medicare contractor opposes an EJR request filed by a group of providers, it must file its response within five (5) business days of the filing of the EJR request.[25] The Medicare Contractor has not filed a response in this case and the time for doing so has elapsed.

Decision of the Board

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

A Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Provider 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; [26]
- The amount in controversy is $10,000 or more.[27]

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 relevant issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital*

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[23] *Id.* at 13-15.
[24] *Id.* at 15 (citing 42 C.F.R. § 405.1867).
[25] Board Rule 42.4 (Nov. 2021). A response in this case (filed July 1, 2022) would be due no later than Friday, July 8, 2022.
[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

Association v. Bowen ("*Bethesda*").[28] 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.[29]

On August 21, 2008, new regulations governing the Board were effective.[30] 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*").[31] 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.[32]

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 Provider in Case No. 22-0681 involves a cost report period which began prior to January 1, 2016 and is governed by CMS Ruling CMS-1727-R since the Provider is challenging a regulation. In addition, the Provider's jurisdictional documentation shows that the estimated amount in controversy exceeds $10,000 as required for an individual appeal.[33] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. The estimated amount in

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[28] 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.).
[29] *Bethesda*, 108 S. Ct. at 1258-59.
[30] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[31] 201 F. Supp. 3d 131 (D.D.C. 2016).
[32] *Id.* at 142.
[33] *See* 42 C.F.R. § 405.1839.

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 Provider asserts 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 Provider asserts 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 Provider presents 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:

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[35] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[36] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the 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:

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[34] EJR Request at 4.
[35] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[36] 66 Fed. Reg. at 39894 (emphasis added).

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

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[38] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[39] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[40] (*i.e*., ratios) using variables a, b, c, and d:

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

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.[41]

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[37] (Emphasis added.)

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

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

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

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

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 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 this case.

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 Provider in Case No. 22-0681 are entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 413.79(c)(2), 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) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As no issues remain pending, Case No. 22-0681 is closed and removed 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:

7/26/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***EJR Determination***
19-2507G King & Spalding CY 2010, 2014 DGME Fellow Penalty Present Year Group
19-2508G King & Spalding CY 2010, 2014 DGME Fellow Penalty Prior & Penultimate Yr. Grp.

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 1, 2022 request for expedited judicial review ("EJR") in the above-referenced appeal. The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statements challenge CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. They explain that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP")) and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Providers contend that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Providers argue that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Providers also note that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and

[1] Group Issue Statement at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.

penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

This appeal concerns 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[10] ("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

[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).
[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

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")[11] 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.[12]

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.[13] 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.

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[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] 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

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> 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.[16]

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).[17] 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.[18]

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[16] *Id.* at 39894 (emphasis added).
[17] *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."
[18] 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.

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.[19]

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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Providers filed an EJR Request for cases 19-2507G and 19-2508G, noting:

> The solitary issue presented in this request for EJR is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).[21]

They note that the Board has previously granted EJR for this issue for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME FTEs violates the Medicare statute.[22] The Providers request the Board grant EJR because it has jurisdiction over all of the group appeals. They claim that the amount in controversy in each case exceeds $50,000, that each provider filed a timely appeal, and that each provider is dissatisfied with their reimbursement for the fiscal years at issue. They also argue that, with regard to this dissatisfaction, CMS Ruling 1727-R applies, and they were not required to self-disallow or protest this issue in order to seek reimbursement on appeal. Specifically, the

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[19] 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.")
[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] EJR Request at 1-2.
[22] *Id.* at 2 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).

Providers argue that the Medicare Contractors were bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which they believe is unlawful, so claiming the cost would have been futile.[23] The Providers request the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[24]

Medicare Contractor's Position

The Board Rules require that, if the Medicare contractor opposes an EJR request filed by a group of providers, it must file its response within five (5) business days of the filing of the EJR request.[25]

On July 7, 2022, the Medicare Contractor filed a timely response to the EJR Request noting that two providers in each case have duplicate filings. A formal Jurisdictional Challenge was filed on July 9, 2022 in each case.

Case 19-2507G (DGME Present Year Group)

The Medicare Contractor argues the two following providers are pursuing a duplicate appeal:

1. Montefiore Hospital Moses Campus (Prov. No. 33-0059, FYE 12/31/2014); and
    a. Case No. 17-0556:
        i. Appealed failure to issue timely final determination from initial cost report
        ii. Appeal included issue for GME Cap Formula (Present Year)
        iii. The Provider withdrew both issues
        iv. On October 13, 2017, the case was closed
    b. Case No. 18-0246G:
        i. Directly added, appealing failure to issue timely final determination from amended cost report
        ii. On July 23, 2019, the Board granted EJR.
2. Gundersen Lutheran Medical Center (Prov. No. 52-0087, FYE 12/31/2014);
    a. Case No. 17-1154:
        i. Appealed failure to issue timely final determination
        ii. Appeal included issue for GME Cap Formula (Present Year)
        iii. Issue was transferred to the optional group under Case No. 18-0246G
        iv. (individual case later closed due to transfers)
    b. Case No. 18-0246G:
        i. On April 23, 2019, the Provider was withdrawn from this group

[23] *Id.* at 15-16.
[24] *Id.* at 16 (citing 42 C.F.R. § 405.1867).
[25] Board Rule 42.4 (Nov. 2021). A response in this case (filed July 1, 2022) would be due no later than Thursday, July 8, 2022.

Case 19-2508G (DGME Prior & Penultimate Years Group)

The Medicare Contractor argues the two following providers are pursuing a duplicate appeal:

1. Montefiore Hospital Moses Campus (Prov. No. 33-0059, FYE 12/31/2014); and
    a. Case No. 17-0556:
        i. Appealed failure to issue timely final determination from initial cost report
        ii. Appeal included issue for GME Cap Formula (Prior & Penultimate Years)
        iii. The Provider withdrew both issues.
        iv. On October 13, 2017, the case was closed.
    b. Case No. 18-0247G:
        i. Directly added, appealing failure to issue timely final determination from amended cost report
        ii. On July 23, 2019, the Board granted EJR.
2. Gundersen Lutheran Medical Center (Prov. No. 52-0087, FYE 12/31/2014);
    a. Case No. 17-1154:
        i. Appealed failure to issue timely final determination
        ii. Appeal included issue for GME Cap Formula (Prior & Penultimate Years)
        iii. Issue was transferred to group case 18-0247G
        iv. (individual case later closed due to transfers)
    b. Case No. 18-0247G:
        i. On April 23, 2019, the Provider was withdrawn from this group

The Medicare Contractor argues that, pursuant to PRRB Rule 4.6.2, "[a]ppeals of the same issue from distinct determinations covering the same time period must be pursued in a single appeal." Additionally, PRRB Rule 4.6.3 sates that "[o]nce an issue is dismissed or withdrawn, the provider may not appeal or pursue that issue in any other case." It also states that the Providers have not filed to reinstate these issues pursuant to the Board Rule 47, and that the time for doing so has elapsed.

As a result, the Medicare Contractor requests these two providers be dismissed from both cases.

Decision of the Board:

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

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

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Providers must appeal from a "final determination" related to their cost report or payment, which includes an NPR, a Revised NPR, or failure to timely issue a final determination; [26]
- The amount in controversy is $10,000 or more.[27]

A. Board Ruling on the Jurisdictional Challenge in Case Nos. 19-2507G and 19-2508G for Montefiore Hospital Moses Campus and Gundersen Lutheran Medical Center

The Board concurs with the Medicare Contractor that the following two (2) providers should be dismissed from both Case Nos, 19-2507G and 19-2508G:

1. Montefiore Hospital Moses Campus (Prov. No. 33-0059, FYE 12/31/2014)
2. Gundersen Lutheran Medical Center (Prov. No. 52-0087, FYE 12/31/2014)

The Board finds that these two providers have pursued the same two DGME issues for the same fiscal years in other cases following different final determinations in violation of Board Rule 4.6. Specifically, these providers pursued the current year DME issue as part of Case No. 18-0246G and the prior and penultimate DGME issue as part of Case No. 18-0247G. On April 23, 2019, Gundersen Lutheran Medical Center was withdrawn from both optional groups and no reinstatement of that Provider has been sought in those cases pursuant to Board Rule 47.1. Further, on July 23, 2019, the Board granted EJR on the DMGE issue in Case Nos. 18-0246G and 18-0247G which included Montefiore Hospital Moses Campus. The Board therefore dismisses both providers from Case Nos. 19-2507G and 19-2508G as prohibited duplicate appeals.

B. Jurisdiction Over the Remaining Providers

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 relevant issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[28] 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

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[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.
[28] 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.).

of a regulation be submitted first to the Medicare Contractor where the contractor is without the power to award reimbursement.[29]

On August 21, 2008, new regulations governing the Board were effective.[30] 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*").[31] 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.[32]

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, providers could elect to self-disallow a specific item deemed non-allowable by filing the matter under protest.

The Board has determined that the remaining providers in Case Nos. 19-2507G & 19-2508G involve a cost report period which began prior to January 1, 2016 and is governed by CMS Ruling 1727-R as they are challenging a regulation. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000 as required for a group appeal.[33] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying ***remaining*** providers (*i.e*., all providers ***except for*** Montefiore Hospital Moses Campus (Prov. No. 33-0059) and Gundersen Lutheran Medical Center (Prov. No. 52-0087) which have been dismissed from both cases). The estimated amount in controversy is subject to recalculation by the Medicare contractor for the actual final amount in each case.

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[29] *Bethesda*, 108 S. Ct. at 1258-59.
[30] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[31] 201 F. Supp. 3d 131 (D.D.C. 2016).
[32] *Id.* at 142.
[33] *See* 42 C.F.R. § 405.1839.

C. Board's Analysis of the Appealed Issue

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

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[35] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[36] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

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

> If the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described

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[34] EJR Request at 4.
[35] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).
[36] 66 Fed. Reg. at 39894 (emphasis added).

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

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[38] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[39] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[40] (*i.e.*, ratios) using variables a, b, c, and d:

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

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.[41]

On the other side of the algebraic equation (*i.e.*, the ratio of "c / d") is the following phrase: "the hospital's weighted FTE count (before application of the limit) . . . will be reduced in the same

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[37] (Emphasis added.)

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

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

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

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

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 this case.

D. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that, ***except for*** Montefiore Hospital Moses Campus (Prov. No. 33-0059) and Gundersen Lutheran Medical Center (Prov. No. 52-0087), the Providers in Case Nos. 19-2507G and 19-2508G[42] are entitled to a hearing before the Board;

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

[42] The Board recognizes that the providers in Case No. 19-2507G and 19-2508G are the same and that, in each case, the providers are challenging the same regulatory language with the only difference being its application to the current year versus the prior and penultimate years. For purposes of administrative ease, the Board did not consolidate Case No. 19-2507G and 19-2508G into a single group even though the groups appealed the same issue. Due to the fact that these cases are being dispensed in the same consolidated EJR and no further proceedings before the Board will occur, the Board opted not to consolidate into one group prior to issuing this EJR determination even though it is treating it as one CIRP group.

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) is valid.

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

Board Members Participating:

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

FOR THE BOARD:

7/26/2022

X Clayton J. Nix

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

Enclosure: Schedules 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***
Gundersen Lutheran Medical Center (Prov. No. 52-0087, FYE 12/31/2013)
Case No. 20-1225

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Provider's July 1, 2022 request for expedited judicial review ("EJR") in the above-referenced appeal. The decision of the Board is set forth below.

Issue in Dispute

The Provider's issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. It explains that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP")) and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Provider contends that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Provider argues that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Provider also notes that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and

[1] Issues 1 & 2 at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.

penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

This appeal concerns 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[10] ("IRP residents") are weighted at 100 percent or 1.0, while FTEs attributable

[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).
[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

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")[11] 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.[12]

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.[13] 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

[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] 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:

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[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *Step 1.* Determine that the hospital's total unweighted FTE counts in the payment year cost reporting period and the prior two immediately preceding cost reporting periods for all residents in allopathic and osteopathic medicine do not exceed the hospital's FTE cap for these residents in accordance with § 413.86(g)(4). *If the hospital's total unweighted FTE count in a cost reporting period exceeds its cap*, the hospital's weighted FTE count, for primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same **proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care **and** obstetrics and gynecology residents and nonprimary care residents separately* in the following manner:
>
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted primary care and obstetrics and gynecology FTEs in the cost reporting period)
> >
> > plus
> >
> > (FTE cap/unweighted total FTEs in the cost reporting period) × (weighted nonprimary care FTEs in the cost reporting period).
>
> Add the two products to determine the hospital's reduced cap.[16]

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).[17] 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

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

> residents for the most recent cost reporting period ending on or before December 31, 1996.[18]

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.[19]

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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Provider filed an EJR Request for this individual case noting

> The solitary issue presented in this request for EJR and in issues 1 and 2 of this individual appeal is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).[21]

It notes that the Board has previously granted EJR for this issue for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME

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[18] 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.
[19] 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.")
[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] EJR Request at 1-2.

FTEs violates the Medicare statute.[22] The Provider requests the Board grant EJR because it has jurisdiction over the appeal. It claims that the amount in controversy exceeds $10,000, that the provider filed a timely appeal, and that the provider is dissatisfied with their reimbursement for the fiscal years at issue. It also argues that, with regard to this dissatisfaction, CMS Ruling 1727-R applies, and it was not required to self-disallow or protest this issue in order to seek reimbursement on appeal. Specifically, the Provider argues that the Medicare Contractor was bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which it believes is unlawful, so claiming the cost would have been futile.[23] The Provider requests the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[24]

Medicare Contractor's Position

The Board Rules require that, if the Medicare contractor opposes an EJR request filed by a group of providers, it must file its response within five (5) business days of the filing of the EJR request.[25] The Medicare Contractor has not filed a response in this case and the time for doing so has elapsed.

Decision of the Board

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

A Provider generally has a right to a hearing before the Board with respect to specific items claimed on timely filed cost reports if

- It is dissatisfied with final determinations of the Medicare Contractor;
- The request for a hearing is filed within 180 days of the date of receipt of the final determinations. Provider 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; [26]
- The amount in controversy is $10,000 or more.[27]

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[22] *Id.* at 2 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).
[23] *Id.* at 13-15.
[24] *Id.* at 15 (citing 42 C.F.R. § 405.1867).
[25] Board Rule 42.4 (Nov. 2021). A response in this case (filed July 1, 2022) would be due no later than Friday, July 8, 2022.
[26] 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).
[27] 42 U.S.C. § 1395oo(a); 42 C.F.R. §§ 405.1835 – 1840.

A. Jurisdiction – An Appeal of Cost Report Period 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 relevant issue as a "self-disallowed cost," pursuant to the Supreme Court's reasoning set out in *Bethesda Hospital Association v. Bowen* ("*Bethesda*").[28] 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.[29]

On August 21, 2008, new regulations governing the Board were effective.[30] 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*").[31] 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.[32]

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.

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[28] 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.).
[29] *Bethesda*, 108 S. Ct. at 1258-59.
[30] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[31] 201 F. Supp. 3d 131 (D.D.C. 2016).
[32] *Id.* at 142.

The Board has determined that the Provider in Case No. 20-1225 involves a cost report period which began prior to January 1, 2016 and is governed by CMS Ruling CMS-1727-R since the Provider is challenging a regulation. In addition, the Provider's jurisdictional documentation shows that the estimated amount in controversy exceeds $10,000 as required for an individual appeal.[33] The appeal was timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal and the underlying provider. 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 Provider asserts 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 Provider asserts 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 Provider presents 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:

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

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

At the outset, the Board notes that, pursuant to the introductory phrase in § 413.79(c)(2)(iii) (*i.e.*, "[i]f the hospital's number of FTE residents in a cost reporting period beginning on or after October 1, 2001 exceeds the limit described in this section [*i.e.*, the FTE cap or limit]"), the above equation is used ***only*** when the "Unweighted FTE Count" for a FY exceeds the "Unweighted FTE Cap" in order to determine what the Providers describe as the "Allowable [weighted] FTE count" for the FY.[35] As such, the equation would logically appear to be a method used to translate the "Unweighted FTE Cap" into a *weighted* context where the "Allowable FTE count" for a FY is really a "weighted FTE cap" for the FY because it is ***only*** used when the unweighted FTE count exceeds the unweighted FTE cap. Indeed, the Board's description of the product of the equation as a "cap" is consistent with the Secretary's description

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[33] *See* 42 C.F.R. § 405.1839.
[34] EJR Request at 4.
[35] *See also* 62 Fed. Reg. at 46005 (describing the purpose of the regulation being adopted in the final rule as follows: "To address situations in which a hospital increases the number of FTE residents over the cap, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's *weighted* direct GME FTE count for cost reporting periods beginning on or after October 1, 1997." (Emphasis added.)).

of it as a "reduced cap" in the preamble to the FY 2002 IPPS Final Rule.[36] Accordingly, the Board will refer to the variable "Allowable FTE count" for the FY as the "Weighted FTE Cap" to facilitate the Board's discussion below on how the equation is conceptually set forth in the text of § 413.79(c)(2)(iii).

Bearing this concept in mind, the Board reviewed the regulation closely and agrees with the 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].[37]

At first blush, it would not appear that the equation is specifically stated in the regulation. However, once the regulation is unpacked around the words "in the same proportion," it is clear that the regulation is relying on ratios as the basis for the equation used to calculate the Weighted FTE Cap applicable for the fiscal year.[38] Indeed, CMS reiterates this in the preamble to the FY 1998 Final Rule by rationalizing § 413.79(c)(2)(iii) as follows: "We believe this ***proportional reduction*** in the hospital's unweighted FTE count is an equitable mechanism for implementing the statutory provision."[39] Essentially, the regulation is stating that the Weighted FTE Cap is to the FY's Weighted FTE Count as the Unweighted FTE Cap is to the FY's Unweighted FTE Count. The calculation of the Weighted FTE Cap is achieved through the operation of the following simple algebraic principle of equivalent fractions[40] (*i.e.*, ratios) using variables a, b, c, and d:

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[36] 66 Fed. Reg. at 39894 (emphasis added).
[37] (Emphasis added.)
[38] *See* 62 Fed. Reg. at 46005 (emphasis added).
[39] *Id.* (emphasis added). *See also* 66 Fed. Reg. at 3984 ("[F]or primary care and obstetrics and gynecology residents and nonprimary care residents, respectively, will be reduced *in the same* ***proportion*** that the number of these FTE residents for that cost reporting period exceeds the unweighted FTE count in the cap. The ***proportional reduction*** is calculated *for primary care* ***and*** *obstetrics and gynecology residents and nonprimary care residents separately…."* (Emphasis added.)).
[40] Two alternative ways to express the algebraic principle of equivalent functions include:
If a/b = c/d, then c = (a x d) / b ; and
If a/b = c/d, then c = (a/b) x d.

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

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.[41]

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

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

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

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

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 this case.

C. Board's Decision Regarding the EJR Request

The Board finds that:

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

1) It has jurisdiction over the matter for the subject year and that the Provider in Case No. 20-1225 are entitled to a hearing before the Board;

2) Based upon the Provider's assertions regarding 42 C.F.R. § 413.79(c)(2), 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) is valid.

Accordingly, the Board finds that the question of the validity of 42 C.F.R. § 413.79(c)(2) properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Provider's request for EJR for the issue and the subject year. The Provider has 60 days from the receipt of this decision to institute the appropriate action for judicial review. As no issues remain in the appeal, Case No. 20-1225 is closed and removed 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:

7/26/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Via Electronic Delivery

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RE: ***EJR Determination***
Houston Methodist CY 2015 DGME Fellow Penalty Prior & Penultimate Years CIRP
Case No. 19-2489GC:

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 1, 2022 request for expedited judicial review ("EJR") in the above-referenced group appeal. The decision of the Board is set forth below.

Issue in Dispute

The Providers' group issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. They explain that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP") and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Providers contend that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Providers argue that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Providers also note that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and

[1] Group Issue Statement at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.

penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

This appeal concerns 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[10] ("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

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[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).
[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

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")[11] 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.[12]

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.[13] 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

[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] 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*

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *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.[16]

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).[17] 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.[18]

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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[16] *Id.* at 39894 (emphasis added).
[17] *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."
[18] 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.[19]

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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Providers filed a EJR Request for this CIRP group case noting

> The solitary issue presented in this request for EJR is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).[21]

They note that the Board has previously granted EJR for this issue for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME FTEs violates the Medicare statute.[22] The Providers request the Board grant EJR because it has jurisdiction over all of the group appeals. They claim that the amount in controversy exceeds $50,000, that each provider filed a timely appeal, and that each provider is dissatisfied with their reimbursement for the fiscal years at issue. They also argue that, with regard to this dissatisfaction, CMS Ruling 1727-R applies, and they were not required to self-disallow or protest this issue in order to seek reimbursement on appeal. Specifically, the Providers argue that the Medicare Contractors were bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which they believe is unlawful, so claiming the cost would have been futile.[23] The Providers request the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[24]

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[19] 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.")
[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] *Id.* at 1-2.
[22] *Id.* at 2 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).
[23] *Id.* at 13-15.
[24] *Id.* at 15 (citing 42 C.F.R. § 405.1867).

Medicare Contractor's Position

The Board Rules require that, if the Medicare contractor opposes an EJR request filed by a group of providers, it must file its response within five (5) business days of the filing of the EJR request.[25] The Medicare Contractor has not filed a response in this case and the time for doing so has elapsed.

Decision of the Board

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

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

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

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

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[25] Board Rule 42.4 (Nov. 2021). A response in this case (filed July 1, 2022) would be due no later than Friday, July 8, 2022.
[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.
[28] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[29] 201 F. Supp. 3d 131 (D.D.C. 2016).

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 in Case No. 19-2489GC involve cost report periods which began prior to January 1, 2016 and are governed by CMS Ruling CMS-1727-R. In addition, the Providers' jurisdictional documentation shows that the estimated amount in controversy exceeds $50,000 in each case, as required for a group appeal.[31] The appeals were timely filed as direct adds to the CIRP group. 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 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:

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [32]

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

[30] *Id.* at 142.
[31] *See* 42 C.F.R. § 405.1839.
[32] EJR Request at 4.

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 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].[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 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

---

[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.)

[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.)).

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:

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

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.[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:

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

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.

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[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.

C. Board's Decision Regarding the EJR Request

The Board finds that:

1) It has jurisdiction over the matter for the subject years and that the Providers in case number 19-2489GC 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 years. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. The case is now closed.

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:

7/26/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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RE: ***Allina II-Type DSH Adjustment Cases***
Case Nos. 13-2059G, *et al.* (*see* attached list of cases)

Dear All,

The Provider Reimbursement Review Board has enclosed its Notice of Reopening that was issued in the above referenced 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:

7/27/2022

X Clayton J. Nix

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

Enclosure: Board Order

cc: Danelle Decker, National Government Services, Inc. (J-K)
Bruce Snyder, Novitas Solutions, Inc. (J-L)
Judith Cummings, CGS Administrators (J-15)
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators (J-E)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Bill Tisdale, Novitas Solutions, Inc. (J-H)
James H. Richards, Ropes & Gray LLP
Alex J. Talley, Ropes & Gray LLP
Kelly A. Carroll, Hooper, Lundy & Bookman, P.C.
Scott Sajack, OGC, CMS Division
David Hoskins, OGC, CMS Division
Jacqueline Vaughn, OAA

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
PROVIDER REIMBURSEMENT REVIEW BOARD

Providers:	*	
ALBERT EINSTEIN HEALTHCARE NETWORK, *ET AL.*	*	
Provider Nos.: Various	*	
v.	*	PRRB Case Nos. 13-2059G *et al.* (See Attached List)
Medicare Contractor:	*	
NATIONAL GOVERNMENT SERVICES, INC., *ET AL.*	*	
FEDERAL SPECIALIZED SERVICES	*	
	*	

* * * * * * * * * * * * *

NOTICE OF REOPENING PURSUANT TO THE PRINCIPAL DEPUTY ADMINISTRATOR'S ORDER FOR REMAND

This case involves numerous providers in a total of thirty-one (31) optional and CIRP group cases (involving 6 different group representatives), all of which have challenged the treatment of Medicare Advantage Days, or Part C Days, in calculating their disproportionate share hospital ("DSH") payments. The Provider Reimbursement Review Board ("Board") dismissed these cases pursuant to 42 C.F.R. § 405.1835(a)(1)(ii) (2008) and the Providers appealed to the United States District Court for the District of Columbia ("D.C. District Court").

On December 2, 2021, the parties submitted a Joint Status Report to the D.C. District Court, and upon consideration of that filing the court issued an order on December 6 remanding the cases to the Secretary of Health and Human Services for further proceedings. Specifically, the D.C. District Court ordered:

> . . . the parties' joint request to voluntarily remand certain cases identified below is GRANTED.
>
> By agreement of the parties, and for good cause shown, the following cases are voluntarily remanded to the Secretary, in whole or in part, as set forth below and the Court vacate[d] challenged decisions by the Provider Reimbursement Review Board dismissing claims under the 2008 self-disallowance regulation, 42 C.F.R. § 405.1835(a)(1)(ii) (2008).

REMAND IN FULL

St. Agnes Medical Center et al., Case No. 18-0222 (Including the following remaining Provider Fiscal Year Claims)
Saint Anne's Hospital, Provider No. 36-0012, FYE 6/30/2011
St. Joseph Mercy Hospital, Provider No. 23-0029, FYE 6/30/2011
St. Ann's Hospital, Provider No. 36-0012, FYE 6/30/2012
St. Joseph Regional Medical Center, Provider No. 15-0012, FYE 6/30/2012
Mount Carmel West, Provider No. 36-0035, FYE 6/30/2012
Mercy Medical Center Sioux City, Provider No. 16-0153, FYE 6/30/2012
St. Joseph Mercy Hospital, No. 23-0156, FYE 6/30/2012
Mercy Medical Center North Iowa, Provider No. 16-0064, FYE 6/30/2012
St. Joseph Mercy Hospital Oakland, Provider No. 23-0029, FYE 6/30/2012
Mercy Hospital & Medical Center, Provider No. 14-0158, FYE 6/30/2012

Grady Memorial v. Azar, Case No. 18-1126 (Including the following remaining Provider Fiscal Year Claims)
Grady Memorial Hospital, Provider No. 11-0079, FYE 12/31/2010
North Memorial Medical Center, Provider No. 24-0001, FYE 12/31/2011

REMAND IN PART (Specific Provider Fiscal Year Claims)

Adcare v. Price, Case No. 17-1896
St. Elizabeth Medical Center, Inc. (18-0035) FYE 12/31/2011
Holyoke Hospital (22-0024) FYE 9/30/2009
The Christ Hospital (36-0163) FYE 6/30/2012
West Chester Hospital (36-0354) FYE 6/30/2011
Grove City Medical Center (39-0266) FYE 6/30/2009
Mount Nittany Medical Center (39-0268) FYE 6/30/2009

St. Mary's v. Hargan, Case No. 17-2106
Aria Health (39-0115) FYE 6/30/2011

Shannon v. Azar, Case No.18-cv-799
EMH Regional Medical Center (36-0145) FYE 12/31/2011
Memorial Hospital (36-0156) FYE 9/30/2011
Sonoma Valley Hospital (05-0090) FYE 6/30/2011
Lima Memorial Hospital (36-0009) FYE 12/31/2011
Memorial Hospital (36-0156) FYE 09/30/2013
UH Bedford Medical Center (36-0115) FYE 12/31/2008
Providence Hospital (42-0026) FYE 12/31/2009

Arizona Regional Medical Center et al. v. Azar, Case No. 18-1367
Mary Lanning Memorial Hospital (28-0032) FYE 12/31/2008
Stevens Healthcare (50-0026) FYE 12/31/2008

EA Conway v. Azar, Case No. 1:18-cv-01415
Earl K. Long Medical Center (19-0122) FYE 06/30/2012
Rockville General Hospital (07-0012) FYE 9/30/2011
Manchester Memorial Hospital (07-0027) FYE 09/30/2011

On June 3, 2022, the Administrator issued an order pursuant to the D.C. District Court's remand. Specifically, the Administrator ordered:

> That these cases are remanded as specified in full or part to the Provider Reimbursement Review Board (PRRB) for further proceedings consistent with the Order of the District Court, which vacated the challenged decisions by the PRRB dismissing claims under the 2008 self-disallowance regulation, 42 C.F.R. § 405.1835(a)(1)(ii)(2008);
>
> **That the PRRB shall revisit the remanded cases, consistent with the court's order and the Secretary's acquiescence in *Banner* *Heart Hospital v. Burwell*.** 201 F. Supp. 3d 131 (D.D.C. 2016);
>
> **That for the remanded cases <u>for which the PRRB determines</u> that – but for the 2008 self-disallowance regulation – <u>it has jurisdiction</u>, the PRRB shall, pursuant to this Order of the Administrator, remand the cases to the appropriate Medicare Administrative Contractor** (MAC) to recalculate the DSH payment adjustments for Part C patient days in accordance with the forthcoming new rule when it is finalized and adopted through notice and comment rulemaking;
>
> That the PRRB remand orders to the MAC will direct the MAC to issue a revised Notice of Program Reimbursement (NPR) that sets forth a DSH payment adjustment that accounts for Part C patient days in the calculation of the disproportionate patient percentage (DPP) in the manner set forth in the forthcoming final rule;
>
> That, even if the final rule embodies the policy currently proposed in CMS 1739P, the MAC will issue a revised NPR that reflects the treatment of Part C days in the DPP adopted through notice-and-comment rulemaking in the new final rule. Specifically, even if the DSH fractions are unchanged or there is no fiscal impact on the DSH payment adjustment of calculating the DPP under the new rule, the fractions will be revised within the meaning of 42 CFR § 405.1877(g)(2)(iii)(A) because they will be issued pursuant to the new final rule; and
>
> That the revised DSH payment adjustments calculated pursuant to the forthcoming final rule to account for Part C patient days in the calculation of the DPP issued in revised NPRs pursuant to this remand order will be subject to appeal, pursuant to 42 CFR § 405.1877(g)(2)(iii)(A).[1]

[1] (Bold and underline emphasis added.)

Pursuant to the Administrator's Order, the Board has reopened the thirty-one (31) cases on the attached list. The Board will be contacting the parties shortly, under separate cover, regarding the Administrator's instruction. In the interim, the Board requests that the parties confer with each other on this issue as appropriate, consistent with Board Rule 1.3 entitled "Good Faith Expectations."

Board Members

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

FOR THE BOARD

7/27/2022

X Clayton J. Nix

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

Enclosure: Board Order

ATTACHMENT
LIST OF REOPENED CASES

13-2059G - Southwest Consulting 2009 DSH Medicaid Fraction Part C Days Group
- Holyoke Hospital (22-0024) FYE 9/30/2009
- Grove City Medical Center (39-0266) FYE 6/30/2009
- Mount Nittany Medical Center (39-0268) FYE 6/30/2009

13-2061G - Southwest Consulting 2009 DSH SSI Fraction Part C Days Group
- Holyoke Hospital (22-0024) FYE 9/30/2009
- Grove City Medical Center (39-0266) FYE 6/30/2009
- Mount Nittany Medical Center (39-0268) FYE 6/30/2009

13-2306G - QRS 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
- Mary Lanning Memorial Hospital (28-0032) FYE 12/31/2008
- Stevens Healthcare (50-0026) FYE 12/31/2008

14-1545GC - HRS UHHS 2008 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP
- UH Bedford Medical Center (36-0115) FYE 12/31/2008

14-1670GC - HRS SCHS 2009 DSH SSI Fraction Medicare Managed Care Part C Days CIRP
- Providence Hospital (42-0026) FYE 12/31/2009

14-1671GC - HRS SCHS 2009 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP
- Providence Hospital (42-0026) FYE 12/31/2009

14-3206G - Southwest Consulting UC Health 2011 DSH SSI Fraction Part C Days CIRP Group
- West Chester Hospital (36-0354) FYE 6/30/2011

14-3209G - Southwest Consulting UC Health 2011 DSH Medicaid Fraction Part C Days CIRP Group
- West Chester Hospital (36-0354) FYE 6/30/2011

14-3240G - HRS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group
- Sonoma Valley Hospital (05-0090) FYE 6/30/2011
- Lima Memorial Hospital (36-0009) FYE 12/31/2011

14-3241G - HRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group
- Sonoma Valley Hospital (05-0090) FYE 6/30/2011
- Lima Memorial Hospital (36-0009) FYE 12/31/2011

14-3576GC - Trinity Health 2011 DSH SSI Medicare Advantage Days CIRP Group
- Saint Anne's Hospital, Provider No. 36-0012, FYE 6/30/2011
- St. Joseph Mercy Hospital, Provider No. 23-0029, FYE 6/30/2011

14-3578GC - Trinity Health 2011 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
- Saint Anne's Hospital, Provider No. 36-0012, FYE 6/30/2011

- St. Joseph Mercy Hospital, Provider No. 23-0029, FYE 6/30/2011

14-3869G - Southwest Consulting SEH 2011 DSH Medicaid Fraction Part C Days CIRP Group
- St. Elizabeth Medical Center, Inc. (18-0035) FYE 12/31/2011

14-4382G - Akin Gump 2010 SSI Fraction Medicare Advantage Days Group
- Grady Memorial Hospital, Provider No. 11-0079, FYE 12/31/2010

14-4383G - Akin Gump 2010 Medicaid Fraction Medicare Advantage Days Group
- Grady Memorial Hospital, Provider No. 11-0079, FYE 12/31/2010

15-0041G - Southwest Consulting 2011 DSH SSI Fraction Part C Days Group II
- Aria Health (39-0115) FYE 6/30/2011

15-0042G - Southwest Consulting 2011 DSH Medicaid Fraction Part C Days Group II
- Aria Health (39-0115) FYE 6/30/2011

15-0416GC - Trinity Health 2012 DSH SSI Medicare Advantage Days CIRP Group
- St. Ann's Hospital, Provider No. 36-0012, FYE 6/30/2012
- St. Joseph Regional Medical Center, Provider No. 15-0012, FYE 6/30/2012
- Mount Carmel West, Provider No. 36-0035, FYE 6/30/2012
- Mercy Medical Center Sioux City, Provider No. 16-0153, FYE 6/30/2012
- St. Joseph Mercy Hospital, No. 23-0156, FYE 6/30/2012
- Mercy Medical Center North Iowa, Provider No. 16-0064, FYE 6/30/2012
- St. Joseph Mercy Hospital Oakland, Provider No. 23-0029, FYE 6/30/2012
- Mercy Hospital & Medical Center, Provider No. 14-0158, FYE 6/30/2012

15-0419GC - Trinity Health 2012 DSH Medicaid Fraction Medicare Advantage Days CIRP Group
- St. Ann's Hospital, Provider No. 36-0012, FYE 6/30/2012
- St. Joseph Regional Medical Center, Provider No. 15-0012, FYE 6/30/2012
- Mount Carmel West, Provider No. 36-0035, FYE 6/30/2012
- Mercy Medical Center Sioux City, Provider No. 16-0153, FYE 6/30/2012
- St. Joseph Mercy Hospital, No. 23-0156, FYE 6/30/2012
- Mercy Medical Center North Iowa, Provider No. 16-0064, FYE 6/30/2012
- St. Joseph Mercy Hospital Oakland, Provider No. 23-0029, FYE 6/30/2012
- Mercy Hospital & Medical Center, Provider No. 14-0158, FYE 6/30/2012

15-0540GC - HRS LSU 2012 DSH SSI Fraction Medicare Managed Care Part C Days CIRP Group
- Earl K. Long Medical Center (19-0122) FYE 06/30/2012

15-0541GC - HRS LSU 2012 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP Group
- Earl K. Long Medical Center (19-0122) FYE 06/30/2012

15-1749G - SWC 2012 DSH SSI Fraction Part C Days Group 2
- The Christ Hospital (36-0163) FYE 6/30/2012

15-1750G - SWC 2012 DSH Medicaid Fraction Part C Days Group 2

- The Christ Hospital (36-0163) FYE 6/30/2012

15-1977GC - HRS ECHN 2011 DSH SSI Fraction Medicare Managed Care Part C Days CIRP

- Rockville General Hospital (07-0012) FYE 9/30/2011
- Manchester Memorial Hospital (07-0027) FYE 09/30/2011

15-1979GC - HRS ECHN 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days CIRP

- Rockville General Hospital (07-0012) FYE 9/30/2011
- Manchester Memorial Hospital (07-0027) FYE 09/30/2011

15-2646G - Akin Gump 2011 Medicare Fraction Medicare Advantage Days Group

- North Memorial Medical Center, Provider No. 24-0001, FYE 12/31/2011

15-2647G - Akin Gump 2011 DSH Medicaid Fraction Medicare Advantage Days Group

- North Memorial Medical Center, Provider No. 24-0001, FYE 12/31/2011

15-2654G - HRS 2011 DSH Medicaid Fraction Medicare Managed Care Part C Days Group II

- EMH Regional Medical Center (36-0145) FYE 12/31/2011
- Memorial Hospital (36-0156) FYE 9/30/2011

15-2655G - HRS 2011 DSH SSI Fraction Medicare Managed Care Part C Days Group II

- EMH Regional Medical Center (36-0145) FYE 12/31/2011
- Memorial Hospital (36-0156) FYE 9/30/2011

15-3342G - HRS 2013 DSH Medicaid Fraction Medicare Managed Care Part C Days Group

- Memorial Hospital (36-0156) FYE 09/30/2013

15-3344G - HRS 2013 DSH SSI Fraction Medicare Managed Care Part C Days Group

- Memorial Hospital (36-0156) FYE 09/30/2013

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Baltimore, MD 21244
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Via Electronic Delivery

Daniel Hettich, Esq.
King & Spalding, LLP
1700 Pennsylvania Ave. NW
Washington, DC 20006

RE: ***EJR Determination***
20-0562G King & Spalding CY 2016 DGME Fellow Penalty Prior & Penultimate Years Grp
22-0361GC Houston Methodist CY 2016 DGME Fellow Penalty Prior & Penultimate CIRP Grp

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' July 1, 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' group issue statement challenges CMS' methodology for calculating payments for DGME, which penalizes a hospital if it trains residents in excess of its unweighted full-time equivalent ("FTE") cap and if any of its residents are fellows. They explain that two statutory provisions govern how FTEs are counted for DGME purposes: 42 U.S.C. § 1395ww(h)(4)(C) (which assigns different weighting factors to fellows and residents in their initial residency period ("IRP")) and 42 U.S.C. § 1395ww(h)(4)(F) (which places a cap on the number of unweighted FTEs that a hospital can count in a given year).[1] The Providers contend that, in effecting these provisions, CMS' created a flawed formula (found at 42 C.F.R. § 413.79(c)(2)(iii)) which penalizes hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement.[2]

The Providers argue that this formula runs counter to the intent of Congress, which "wants hospitals to fully utilize their FTE cap slots," and that there is "simply no indication . . . that Congress intended to penalize hospitals for training residents in excess of the number of residents they can claim for DGME reimbursement."[3] The Providers also note that this policy resulted in an understatement of DGME reimbursement because the prior and penultimate year weighted resident FTE counts were understated due to the same CMS policy.[4] The prior and penultimate year FTE counts are relevant because the Medicare statute requires that a hospital's FTE must be averaged over the present, prior, and penultimate years.[5]

[1] Group Issue Statement at 1.
[2] *Id.* at 2-3.
[3] *Id.*
[4] *Id.* at 4.
[5] EJR Request at 10 (citing 42 U.S.C. § 1395ww(h)(4)G)(i)).

Background

The Medicare statute requires the Secretary[6] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[7] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[8]

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.[9]

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[10] ("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.

---

[6] of the Department of Health and Human Services.
[7] 42 U.S.C. § 1395ww(h).
[8] *See* S. Rep. No. 404, 89th Cong. 1st Sess. 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[9] 42 U.S.C. § 1395(h).
[10] "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).

On August 5, 1997, Congress enacted § 4623 of the Balanced Budget Act of 1997 ("BBA")[11] 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.[12]

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.[13] Specifically, in the FY 1998 inpatient prospective payment system ("IPPS") final rule published on August 20, 1997 ("FY 1998 IPPS Final Rule"), CMS promulgated revisions to 42 C.F.R. § 413.86(g)(4) and included the following explanation in the preamble to that rule:

> *To address situations in which a hospital increases the number of FTE residents* ***over*** *the cap*, notwithstanding the limit established under section 1886(h)(4)(F), we are establishing the following policy for determining the hospital's weighted direct GME FTE count for cost reporting periods beginning on or after October 1, 1997.
>
> • *Determine the ratio of* the hospital's unweighted FTE count for residents in those specialties for the most recent cost reporting period ending on or before December 31, 1996, *to* the hospital's number of FTE residents without application of the cap for the cost reporting period at issue.

[11] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[12] 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.
[13] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> • *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.[14]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[15] Therein, the Secretary modified the allowable FTEs formula so that the proportionate reduction to the weighted FTE count would be calculated separately for FTEs attributable to residents trained in primary care, obstetrics and gynecology programs and residents training in nonprimary care programs. In that final rule, the modified methodology, effective for cost report periods beginning on or after October 1, 2001 was:

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

[14] 62 Fed. Reg. at 46005 (emphasis added).
[15] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *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.[16]

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).[17] 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.[18]

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.[19]

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:

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[16] *Id.* at 39894 (emphasis added).
[17] *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."
[18] 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.
[19] 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.")

> [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.[20]

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.

Providers' EJR Request

On July 1, 2022, the Providers filed an EJR Request for this optional group case noting

> For all but one of the Providers in this group appeal, there is only one issue presented in this petition for EJR. That issue is whether the formula for calculating the number of [FTE] residents a hospital may count in a year for the purposes of [DGME] 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).
>
> . . . .
>
> There is a *second* issue presented in this petition for EJR for Houston Methodist San Jacinto Hospital (Provider No. 45-0424) in the Houston Methodist CY 2016 DGME Fellow Penalty Prior & Penultimate Years group. That issue is whether the self-disallowance regulation at 42 C.F.R. § 413.24(j)(1)(ii) is unlawful insofar as it requires providers to self-disallow items in their cost report if they seek payment that they believe "may not be allowable or may not comport with Medicare policy," even if such claims are futile because Medicare Administrative Contractors ("MACs") have no authority to allow them (the "Self-Disallowance" issue). . . . Since Houston Methodist San Jacinto Hospital admittedly did not self-disallow the Fellow Penalty issue in its cost report for the reporting period under appeal and stipulates to that fact, it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful.[21]

They note that the Board has previously granted EJR for ***both*** of these issues for similarly situated providers, and that the District Court for the District of Columbia has held the formula for counting DGME FTEs violates the Medicare statute.[22] The Providers request the Board grant EJR because it has jurisdiction over all of the group appeals. They claim that the amount in controversy exceeds $50,000, that each provider filed a timely appeal, and that each provider is dissatisfied with their reimbursement for the fiscal years at issue. They also argue that, with

[20] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[21] *Id.* at 1-2.
[22] *Id.* at 1-2, 27-28 (citing *Milton S. Hershey Med. Ctr. v. Becerra*, 19-CV-2311, 2021 WL 1966572 (D.D.C. 2021)).

regard to this dissatisfaction, either (1) CMS Ruling 1727-R applies;[23] (2) the provider complied with the self-disallowance regulations; or (3) that the self-disallowance regulations are unlawful.[24] Specifically, the Providers argue that the Medicare Contractors were bound to implement the regulatory formula set forth in 42 C.F.R. § 413.79(c)(2)(iii), which they believe is unlawful, so claiming the cost would have been futile.[25] With regard to Houston Methodist San Jacinto Hospital, they note that this provider did not self-disallow the item under appeal, but argue that the self-disallowance regulations are unlawful. The Providers request the Board grant EJR because the Board cannot declare the regulations at issue to be unlawful and it does not have the authority to rule on the validity of the Secretary's regulations.[26]

Medicare Contractor's Position

On July 7, 2022, the Medicare Contractor filed a response to the EJR request stating:

> The participants in the group case number 20-0562G requested EJR on 07/01/22. The MAC has no objections to the provider's EJR request.

The response did not address case 22-0361GC.

Decision of the Board

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

A. Jurisdiction

As explained at 42 C.F.R. § 1837(a), a provider 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 -

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

[23] *Id.* at 24-26.
[24] *Id.* at 18-23.
[25] *Id.* at 25-26.
[26] *Id.* at 26-27 (citing 42 C.F.R. § 405.1867).

(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.

Each of the Providers in Case No. 20-0562G have fiscal years beginning prior to January 1, 2016. In contrast, both Providers in Case No. 22-0361GC have cost reporting periods beginning on or after January 1, 2016.

1. Case No. 20-0562G – Jurisdiction Over the Providers With FYEs Beginning Prior to January 1, 2016

All four (4) providers[27] in Case No. 20-0562G have fiscal years beginning prior to January 1, 2016 and are subject to CMS Ruling 1727-R:

1. University of Iowa Hospital & Clinics (FYE 6/30/2016)
2. University of Kansas Hospital (FYE 6/30/2016)
3. Froedtert Memorial Lutheran Hospital (FYE 6/30/2016)
4. University of Cincinnati Medical Center, LLC (FYE 6/30/2016)

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. In short, a provider has a right to a Board hearing for a cost item if it excluded the item based upon "a good faith belief that the item was subject to a payment regulation or other policy that gave

[27] As noted above, the case was fully formed with five (5) providers, but this decision has transferred one to case 22-0361GC.
[28] 73 Fed. Reg. 30190, 30240 (May 23, 2008).
[29] 201 F. Supp. 3d 131 (D.D.C. 2016)
[30] *Banner* at 142.

the Medicare contractor no authority or discretion to make payment in the manner the provider sought."[31]

The first step of analysis under 1727-R involves the appeal's filing date and cost reporting period. The appeal must have been pending or filed after the Ruling was issued on April 23, 2018. This group appeal was formed on December 31, 2019, so it satisfies the appeal pending date requirement. Additionally, the Ruling applies to appeals of cost reporting periods that ended on or after December 31, 2008 and began before January 1, 2016. Four (4) providers in case 20-0562G involve fiscal years ending June 30, 2016, so those cost reporting periods fall within the required time frame.

Second, the Board must determine whether the appealed item "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider."[32] The Providers are challenging the validity of 42 C.F.R. § 413.79(c)(2), which determines the FTE cap after application of weighting factors. Thus, the Board should find that the Providers' DGME Penalty issue "was subject to a regulation or other payment policy that bound the [Medicare] contractor and left it with no authority or discretion to make payment in the manner sought by the provider." The regulation states that the Medicare Contractor "will" reduce the weighted FTE count and does not say that it "may" reduce the weighted FTE count. In other words, the Board should find that this issue meets the second requirement or step of Ruling 1727.

The third, fourth and fifth steps of analysis under Ruling 1727 involve the Board's assessment of whether a provider's appeal has met the jurisdictional requirements set out in 42 C.F.R. § 405.1835. Since the Providers' appeals were timely filed and the estimated amount in controversy is over $50,000, the first two Board jurisdictional requirements have been met. With respect to the "dissatisfaction" requirement, Ruling 1727 sets out three different scenarios—in steps three, four and five—for the Board to consider.

The Board looks to step three if it is reviewing an appealed item which was, in fact, within the payment authority or discretion of the Medicare contractor, i.e., an "allowable" item. In the instant appeal, the reduction of the weighted FTE count was <u>not</u> within the payment authority or discretion of the Medicare Contractor because the pertinent regulation specifically dictates how to calculate the FTE count.

Under step four of Ruling 1727, the Board does not apply the self-disallowance jurisdiction regulation (in § 405.1835(a)(1)(ii) or § 405.1811(a)(1)(ii), as applicable) if a determination has been made that the item under appeal was subject to a regulation or other policy that bound the Medicare Contractor and left it with no authority or discretion to make payment as sought. As discussed in step two above, the Medicare Contractor was bound by regulation at 42 C.F.R. § 413.79(c)(2), and therefore the Board should "not apply the self-disallowance jurisdiction regulation" in this jurisdictional decision.

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[31] Ruling 1727 at unnumbered page 2.
[32] *Id.* at unnumbered page 6.

Under step five of Ruling 1727, the Board is directed to consider the circumstances surrounding a provider's self-disallowance claim. If a Provider self-disallows a specific item by filing the pertinent parts of its cost report under protest, but the Board determines that the Medicare Contractor actually had the authority or discretion to make payment for that specific item, then the Board must apply step three of 1727-R. As discussed above, the Medicare Contractor did not have the authority deviate from the applicable regulation. As a result, this step is not a barrier to the instant appeal.

2. *Case No. 22-0361GC – Jurisdiction Over the Providers With FYEs Beginning On or After 1/01/2016*

In the November 13, 2015 Final Outpatient Prospective Payment Rule,[33] the Secretary finalized new cost reporting regulations related to the substantive reimbursement requirement of an appropriate cost report claim.[34] The Secretary revised the Medicare cost reporting regulations in 42 C.F.R. part 413, subpart B, by requiring a provider to include an appropriate claim for a specific item in its Medicare cost report *beginning on or after January 1, 2016* in order to receive or potentially qualify for Medicare payment for the specific item. If the provider's cost report does not include an appropriate claim for a specific item, the Secretary stated that payment for the item will not be included in the NPR issued by the Medicare Contractor or in any decision or order issued by a reviewing entity (as defined in 42 C.F.R. § 405.1801(a)) in an administrative appeal filed by a provider. In addition, the Secretary revised the appeals regulations in 42 C.F.R. part 405, subpart R, by eliminating the requirement that a provider must include an appropriate claim for a specific item in its cost report in order to meet the dissatisfaction requirement for jurisdiction before the Board, again, for cost reports beginning on or after January 1, 2016 (hereinafter the "claim-specific dissatisfaction requirement"). Both Providers in Case No. 22-0361GC have filed appeals involving fiscal years beginning on or after January 1, 2016:

- Houston Methodist Hospital (FYE 12/31/2016) (formerly in Case 20-0562G)[35]
- Houston Methodist San Jacinto Hospital (FYE 12/31/2016)

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

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[33] 80 Fed. Reg. 70298, 70551-70580 (Nov. 13, 2015).
[34] *Id.* at 70555.
[35] At the time of EJR Request, Case 22-0361GC had only one (1) provider with an amount in controversy of $30,502. The Provider alone did not satisfy the requirements for a group appeal. However, in the EJR request the Providers requested to transfer of Houston Methodist Hospital from case 20-0562G to 22-0361GC, Houston Methodist CY 2016 DGME Fellow Penalty Prior & Penultimate Years CIRP Group because they are commonly owned. This action would add $23,170 to the amount in controversy for a cumulative amount of $53,672. In a subsequent action dated July 26, 2022, the Board granted the transfer request, finding Houston Methodist Hospital is commonly owned, and since there is a CIRP group established with its parent company for the issue and fiscal year under appeal, this Provider must pursue its appeal in a CIRP group. Therefore, there are two providers now in 22-0361GC, that meet the $50,000 threshold.

B. Case No. 22-0361GC – Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. § 405.1873 and 413.24(j) for Cost Reports Beginning on or After January 1, 2016

1. Regulatory Background

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

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

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

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

These regulations are applicable to the cost reporting periods under appeal for the two providers noted above in Case No. 22-0361GC, which both have cost reporting periods beginning on or after January 1, 2016.

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

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

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[36] 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.[37] The Medicare Contractor has failed to file a Substantive Claim Challenge[38] within the time frame specified by Board Rule 44.5.1 (2021) for any of the Providers with FYEs December 31, 2016.

However, in its EJR request, the Providers' representative conceded that "Houston Methodist San Jacinto Hospital admittedly did not self-disallow the Fellow Penalty issue in its cost report for the reporting period under appeal and stipulates to that fact, it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful."[39] Accordingly, Board review under 42 C.F.R. § 405.1873(b) has been triggered because a party has questioned the Provider's compliance with § 413.24(j) as described at § 405.1873(a).

The regulation at 42 C.F.R. § 413.24(j)(3) provides:

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[36] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[37] *See* 42 C.F.R. § 405.1873(a).
[38] Board Rule 44.5 states: "The Board adoption of the term 'Substantive Claim Challenge' simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."
[39] *Id.* at 1-2.

> ***Procedures for determining whether there is an appropriate cost report claim***. Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:
>
> (i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;
>
> (ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;
>
> (iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

Applying that regulation to Houston Methodist San Jacinto Hospital, Provider No. 45-0424, the cost report that the Provider originally submitted, and was accepted by, the contractor will be referenced to make this determination, as none of the exceptions in the regulation apply to the circumstances of this Provider.[40] Further, in the EJR request, the Provider has stipulated to the

[40] *See* 42 C.F.R. § 413.24(j)(3).

facts that there were neither contractor adjustments nor self-disallowance with respect to specific cost report claims for the DGME fellows penalty issue on appeal.[41]

Based on the above and pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that it is undisputed that Houston Methodist San Jacinto Hospital failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2) in 22-0361GC.[42]

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

As noted above, the original EJR Request covering the DGME issue conceded that Houston Methodist San Jacinto Hospital did not self-disallow the DGME issue in its cost report for the reporting period under appeal. It went on, however, to state that "it seeks to have the self-disallowance regulation at 42 C.F.R. § 413.24(j) declared unlawful."[43] The Board interprets this statement as a request for EJR over the substantive claim regulations for this provider, in addition to the DGME issue.

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the challenge made by St. Joseph's Regional Medical Center regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal.[44] Since there is no factual dispute regarding the Provider's lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of St. Joseph's Regional Medical Center's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, 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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

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[41] *See id.* at § 413.24(j)(3)(ii). On review of the Provider's Worksheet E-4 submitted for the period at issue, the Provider did not self-disallow the specific item or issue under appeal. *See Provider Reimbursement Manual*, Pt. II, ch. 40, § 1034 (June 30, 2015) ("Use this worksheet to calculate each program's payment (i.e., titles XVIII, and XIX) for direct graduate medical education (GME) costs as determined under 42 CFR 413.75 through 413.83. This worksheet applies to the direct graduate medical cost applicable to interns and residents in approved teaching programs in hospitals and hospital-based providers."

[42] The Board recognizes that the Group Representative filed a challenge to the regulation at 42 C.F.R. § 413.24(j) as part of its EJR request.

[43] *Id.*

[44] The Board recognizes that this question relates only to Houston Methodist San Jacinto Hospital and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to Houston Methodist San Jacinto Hospital.

C. Board's Analysis of the Appealed Issue

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

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [45]

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.[46] 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.[47] 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

[45] EJR Request at 4.
[46] *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.)).
[47] 66 Fed. Reg. at 39894 (emphasis added).

> 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].[48]

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.[49] 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."[50] 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[51] (*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.[52]

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:

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[48] (Emphasis added.)

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

[50] *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.)).

[51] 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.

[52] 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.

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

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.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) *In Case No. 22-0361GC*, Houston Methodist San Jacinto Hospital did not make a specific claim for the issue under appeal as required under 42 C.F.R. § 413.24(j);

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

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

5) It is without the authority to decide the legal question of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, with respect to Houston Methodist San Jacinto Hospital *In Case No. 22-0361GC*, whether the regulations at 42 C.F.R. §§ 413.24(j) and 405.1873 are valid.

Accordingly, the Board finds that the questions in Finding 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the DGME issue and the Providers' request for EJR *in Case No. 22-0361GC* (as it pertains to Houston

Methodist San Jacinto Hospital) for the validity of the substantive claim regulation at 42 C.F.R. §§ 413.24(j) and 405.1873. 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 two appeals, the Board hereby closes them 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:

7/27/2022

X Clayton J. Nix

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

Enclosure: Schedule of Providers

cc: Byron Lamprecht, WPS Government Health Administrators (J-5)
Bill Tisdale, Novitas Solutions, Inc. (J-H)
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
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Via Electronic Delivery

Daniel Hettich, Esq.
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1700 Pennsylvania Ave., NW
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RE: ***EJR Determination***
19-0823GC - Cleveland Clinic Health CY 2016 DGME Fellow Penalty Present Year CIRP Grp
19-0824GC - Cleveland Clinic Health CY 2016 DGME Fellow Penalty Prior & Penultimate Yrs. CIRP

Dear Mr. Hettich:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' May 9, 2022 requests for expedited judicial review ("EJR") that were submitted in these two cases. The Board notes that the two EJR requests submitted in these two cases are identical except for the case number and case name. On June 2, 2022, the Board granted FSS' request for an extension of time to respond to the Providers' EJR requests.

On June 6, 2022, FSS filed two separate "substantive claim challenges,"[1] one for each case at issue, indicating they have determined that two of the four Providers, namely Cleveland Clinic (Provider No. 36-0180) and Akron General Medical Center (Provider No. 36-0027), failed to include appropriate claims. On June 7, the Medicare Contractor ("MAC") filed Board Rule 22 letters in the two cases, indicating in both that the appeal issue is suitable for a group appeal and that no jurisdictional impediments exist for this group. On June 30, 2022, the Providers' responded to the substantive claim challenges. The Providers' assert that Akron General Medical Center protested the appealed issue and acknowledge that Cleveland Clinic did not. However, the Providers assert that neither provider was required to comply with the self-disallowance rule because it is unlawful.

The Board has reviewed and considered each of these filings. The decision of the Board is set forth below.

Issue in Dispute

The issue for which EJR was initially requested in these two cases is:

> [W]hether the formula for calculating the number of full-time equivalent ("FTE") residents a hospital may count in a year for the

[1] As noted in Board Rule 44.5, "The Board adoption of the term "Substantive Claim Challenge" simply refers to any question raised by a party concerning whether the cost report at issue included an appropriate claim for one or more of the specific items being appealed in order to receive or potentially qualify for reimbursement for those specific items."

> purpose of [DGME] 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.[2]

Background

The Medicare statute requires the Secretary[3] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[4] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[5]

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.[6]

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

The Medicare Statute

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

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

Pursuant to this statutory provision, FTEs attributable to residents who are training in their initial residency period[7] ("*IRP residents*") are weighted at 100 percent or 1.0, while FTEs attributable

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[2] Provider's EJR Requests at 1.
[3] of the Department of Health and Human Services.
[4] 42 U.S.C. § 1395ww(h).
[5] *See* S. Rep. No. 404, 89th Cong. 1st Sess 36 (1965); H.R. No 213, 89th Cong., 1st Sess. 32 (1965).
[6] 42 U.S.C. § 1395(h).
[7] "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).

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")[8] 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.[9]

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.[10] 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.

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[8] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).
[9] 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.
[10] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 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.[11]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[12] 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*

[11] 62 Fed. Reg. at 46005 (emphasis added).
[12] 66 Fed. Reg. 39826 (Aug. 1, 2001).

> *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.[13]

To codify this change, the Secretary added clause (iii) to § 413.86(g)(4). In the final rule published on the August 11, 2004, CMS relocated 42 C.F.R. § 413.86(g)(4)(iii) to 42 C.F.R. § 413.79(c)(2)(iii).[14] This regulation is the focus of these appeals and the EJR requests, 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.[15]

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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[13] *Id.* at 39894 (emphasis added).
[14] *See* 69 Fed. Reg. 48916, 49258-64. As part of the relocation, CMS modified the language slightly by removing the references to "paragraph (g)" that were in the prior version of the regulation and replacing them with reference to "the limit described in this section."
[15] 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.[16]

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.[17]

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

In the two identical EJR requests, 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. This reduction is accomplished 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). This results in the hospital's allowable FTE count.[18]

The Providers point out that the regulation only applies when hospitals report residents in excess of their cap level. Consequently, if a hospital's unweighted FTE count for allopathic and osteopathic residents is less than or equal to its cap, its weighted FTEs are not reduced.[19]

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 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.[20]

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

[16] 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.")
[17] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[18] EJR Requests at 1-2, 9-10.
[19] *Id.* at 8-10.
[20] *Id.* at 15-17.

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.[21]

Since the FTE counts from the prior and penultimate years were determined in cost reporting periods preceding the payment years under appeal, the Providers note that they may be considered by CMS to be "predicate facts." The Providers point out that CMS has interpreted the three-year limitations period in the reopening regulation at 42 C.F.R. § 405.1885(b)(2)(i) as prohibiting providers from appealing predicate facts in cost report appeals. However, that interpretation was rejected in *Saint Francis Medical Center v. Azar*[22] (*"St. Francis*") which concluded that "42 C.F.R. § 405.1885(b)(2)(i) does not apply to appeals from a fiscal intermediary to the PRRB."[23]

One of the Providers, Cleveland Clinic Hospital (Provider No. 36-0180), acknowledges that it did not self-disallow the DGME penalty issue on its Medicare cost reports for the reporting periods under appeal and stipulates to that fact. Moreover, the Provider asserts that even though it did not self-disallow the fellow penalty in its cost reports, the Provider is nonetheless entitled to payment because the self-disallowance regulation at 42 C.F.R. § 413.24(j) is unlawful. The Provider asserts that regulation is unlawful insofar as it requires providers to self-disallow items in their cost report if they seek payment that they believe "may not be allowable or may not comport with Medicare policy," even if such claims are futile because the Medicare Contractors have no authority to allow them.[24]

In sum, the Provider 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). Further, the Board lacks the authority to determine the validity of 42 C.F.R. § 413.24(j) or grant the relief requested by the Provider pursuant to the substantive reimbursement requirement of an appropriate cost report claim under 42 C.F.R. § 413.24(j). For these reasons, the Provider asserts that the Board should grant its request for EJR on these two issues.[25]

FSS' Substantive Claim Challenge and Providers' Response

In two separate filings, one for each case, the MAC contends in each that there is nothing in the record to show where two of the Providers, Cleveland Clinic and Akron General Medical Center, attempted to claim the disputed items for full reimbursement following a belief that the items comported with Program policy. The MAC asserts that the requirements of 42 C.F.R. § 413.24(j)(1)-(2) were not met, and that none of the exceptions in subsections (j)(3) apply. Therefore, the MAC requests that the Board find for these two Providers, that there is not an appropriate cost report claim for the specific items in dispute, and that the items are not

[21] *Id.* at 1, 5, 10.
[22] 894 F.3d 290 (D.C. Cir. 2018).
[23] EJR Requests at 22-23 n.63.
[24] *Id.* at 2.
[25] *Id.* at 22.

reimbursable, regardless of whether the Board further determines in a final hearing decision that the other substantive reimbursement requirements for the specific items are or are not satisfied.

In two separate responses, one for each case, the Group Representative asserts in each that the Provider Akron General Medical Center self-disallowed the DGME fellow penalty issue. The Group Representative explained that at the time of filing its appeals, the Provider represented to the Board that it protested the DGME fellow penalty issue in its cost report, but inadvertently uploaded the protest documentation that was submitted with its original as-filed cost report instead of its most recent amendment. That cost report submission was accompanied by a spreadsheet with a breakdown of the total amount disallowed on Line 75 of Worksheet E, Part A, including $2,505,244 for the DGME fellow penalty. That spreadsheet also shows how that $2,505,244 was calculated.

With regard to the Cleveland Clinic, the Provider acknowledges that it did not protest the fellow penalty issue, but argues that neither of the two Providers was required to comply with the rule because it is unlawful, as described above in the Providers' EJR arguments, and as discussed in more detail below.

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

As explained at 42 C.F.R. § 1837(a), a provider 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 -

(1) The provider satisfies individually the requirements for a Board hearing under § 405.1835(a) or § 405.1835(c), except for the $10,000 amount in controversy requirement in § 405.1835(a)(2) or § 405.1835(c)(3).

(2) The matter at issue in the group appeal involves a single question of fact or interpretation of law, regulations, or CMS Rulings that is common to each provider in the group; and

(3) The amount in controversy is, in the aggregate, $50,000 or more, as determined in accordance with § 405.1839 of this subpart.

All the providers in case numbers 19-0823GC and 19-0824GC have cost reporting periods beginning on or after January 1, 2016.

1. *Jurisdiction Over the Appeals of Predicate Facts Involving the Prior and Penultimate Years*

   a) *The 2013 Kaiser Case and CMS's Subsequent Revisions to 42 C.F.R. § 405.1885*

In 2013, the D.C. Circuit issued its decision in *Kaiser Foundation Hospital v. Sebelius* ("*Kaiser*") holding that "the reopening regulation allow[ed] for modification of predicate facts in closed years provided the change will only impact the total reimbursement determination in open years."[26] The *Kaiser* case also involved the statutory cap on indirect medical education (IME) FTEs in base year cost reports, and the D.C. Circuit examined whether or not predicate facts could be corrected beyond the 3 year re-opening limit contained in 42 C.F.R. § 405.1885. In finding for the Providers, the D.C. Circuit rejected CMS' arguments that modification of predicate facts in closed years constitutes an impermissible reopening, and that even if not a reopening, the modification necessitates an adjustment to the closed year's reimbursement.[27]

CMS disagreed with the *Kaiser* decision, and in response, revised 42 C.F.R. § 405.1885 as part of the Calendar Year 2014 Outpatient Prospective Payment System and Medicare Ambulatory Surgical Center Payment System Final Rule ("CY 2014 OPPS/ASC Final Rule"). In the preamble to this final rule, CMS gave the following explanation for its revisions to § 405.1885:

> [W]e are adopting the proposed revisions to §§ 405.1885(a)(1) and (a)(2)(iv) to clarify that the specific "matters at issue in the determination" that are subject to the reopening rules include factual findings for one fiscal period that are predicate facts for later fiscal periods with the following modifications: We are adding language to paragraph (a)(1)(iii) that defines the "predicate facts" that are subject to the revisions as factual findings for one cost reporting period that once determined are used in one or more subsequent cost reporting periods to determine reimbursement. We are adding language to paragraph (b)(2)(iv) to clarify that it does not apply to factual findings when made as part of a determination of reasonable cost under section 1861(v)(1)(A) of the Act. Paragraph (a)(1)(iv) also was reworded for clarity. Absent a specific statute, regulation or other legal provision permitting reauditing, revising, or similar actions changing predicate facts:
>
> (1) A predicate fact is subject to change only through a timely appeal or reopening of the NPR for the fiscal period in which the predicate fact first arose of the fiscal period for which such fact was first determined by the intermediary; and/or
>
> (2) the application of the predicate fact is subject to change through a timely appeal or reopening of the NPR for the fiscal

[26] *Kaiser Found. Hosps. v. Sebelius,* 708 F.3d 226, 229 (D.C. Cir. 2013).
[27] *Id.* at 229.

> period in which the fact was first used (or applied), by the intermediary to determine the provider's reimbursement.[28]

CMS further stated that the revision to 42 C.F.R. § 405.1885 "would apply to *all* Medicare reimbursement determinations, and *not only* to direct GME payment, which was the particular issue in *Kaiser* . . . ."[29] CMS further stated that the revision would apply to any final determination "issued on or after the effective date of the final rule, and for any appeals or reopening . . . pending on or after the effective date of the final rule, even if the intermediary determination . . . preceded the effective date of the final rule."[30] The effective date of the revised 42 C.F.R. § 405.1885 was January 1, 2014.[31]

b) The Saint Francis Case

In June 2018, the D.C. Circuit revisited the issue of predicate fact as part of *Saint Francis.* Specifically, in *Saint Francis*, the D.C. Circuit reviewed CMS' 2013 revision to 42 C.F.R. § 405.1885 and held "that 42 C.F.R. § 405.1885 does not apply to appeals from a fiscal intermediary to the PRRB."[32] The Court reasoned that "[t]he reopening regulation applies *only* to reconsideration by the entity that made the decision at issue. It does not apply to administrative appeals."[33] The Court explained that a reopening occurs when various administrative actors within the agency reconsider *their own prior decisions*. The case was remanded to the agency for further proceedings consistent with the D.C. Circuit's opinion.

The Secretary has not formally acquiesced to the *Saint Francis* decision as of yet. The Board notes that the regulation was amended in 2020 but only in regard to language relating to mailing and receipt of requests to reopen.[34] However, it is clear from the *Saint Francis* case that the D.C. Circuit did not invalidate 42 C.F.R. § 405.1885 but rather ***interpreted*** the reopening regulation at 42 C.F.R. § 405.1885 to *not* apply to appeals before the Board because they involve the Board reviewing a Medicare Contractor final determination. Further, the D.C. Circuit's decision in *Saint Francis* is controlling precedent for the ***interpretation*** of 42 C.F.R. § 405.1885 (as revised in 2013) because the Providers could bring suit in the D.C. Circuit.[35] Accordingly, the Board finds it is not bound by the Secretary's "longstanding policy" that predicate facts may only be redetermined by a timely appeal of the final determination in which the predicate fact first arose or was applied.

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[28] 78 Fed. Reg. 74826, 75169 (Dec. 10, 2013).
[29] *Id.* at 75165.
[30] *Id.*
[31] *Id.* at 74826.
[32] *Saint Francis Med. Ctr. v. Azar,* 894 F.3d 290, 297 (citation omitted).
[33] *Id.* at 294 (emphasis added).
[34] 85 Fed. Reg. 58432, 59019-20 (Sept. 18, 2020).
[35] The CMS Administrator generally has applied as controlling precedent the law of the Circuit in which the Provider is located. *See, e.g., QRS CHW DSH Labor room Days Groups v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Apr. 13, 2009), affirming, PRRB Dec. No. 2009-D11 (Feb. 27, 2009); *St. Vincent Mercy Med. Ctr. v. BlueCross BlueShield Ass'n*, Adm'r Dec. (Nov. 17, 2008), *affirming in part and reversing in part*, PRRB Dec. No. 2008-D35 (Sept. 15, 2008). However, in recognizing that providers may file suit with the appropriate District Court either in the Circuit in which they are located or the D.C. Circuit, the Administrator also applies as controlling precedent the law of the D.C. Circuit. *See, e.g., Jordan Hosp. v. Blue Cross Blue Shield Ass'n.*, Adm'r Dec. (Apr. 30, 2007), *vacating*, PRRB Dec. No. 2007-D23 (Feb. 28, 2007).

Based on the above, the Board finds that it has the authority to decide the FTE issue as it relates to the FTE counts for the prior and penultimate years under appeal because, under *Kaiser* and *Saint Francis*, providers may appeal and the Board may modify a predicate fact *as it relates to the open years under appeal.* As such, the Board has substantive jurisdiction over the prior and penultimate year issues.

2. Jurisdiction Findings

The Providers in these two group cases appealed from the Medicare Contractor's NPR final determinations. The Providers filed timely appeals and the Board's consideration of the common issue in these appeals is not precluded by statute or regulation. The aggregate amount in controversy exceeds the $50,000 threshold for group appeals.[36] Accordingly, the Board finds that it has jurisdiction over these two cases pursuant to 42 C.F.R. § 405.1837.

B. Board review of compliance with the reimbursement requirement of an appropriate cost report claim pursuant to 42 C.F.R. §§ 405.1873 and 413.24(j) for Cost Reports Beginning on or After January 1, 2016

1. Regulatory Background

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

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

[36] *See* 42 C.F.R. § 405.1837.

> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
>
> (i) Include an estimated reimbursement amount for each specific self-disallowed item in the protested amount line (or lines) of the provider's cost report; and
>
> (ii) Attach a separate work sheet to the provider's cost report for each specific self-disallowed item, explaining why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item) and describing how the provider calculated the estimated reimbursement amount for each specific self-disallowed item.[37]

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

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

[37] (Bold and underline emphasis added.)

> (2) Board expedited judicial review (EJR) decision, where EJR is granted. **If the Board issues an EJR decision where EJR is granted** regarding a legal question that is relevant to the specific item under appeal (in accordance with § 405.1842(f) (1)), **the Board's specific findings of fact and conclusions of law** (reached under paragraph (b)(1) of this section), on the question of whether the provider's cost report included an appropriate claim for the specific item, **must be included in such EJR decision** along with the other matters prescribed by 405.1842(f)(1). . . .[38]

These regulations are applicable to the cost reporting periods in these two cases, which begin on January 1, 2016.

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

As explained above, at issue in these two appeals are cost reports beginning on January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[39] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning January 1, 2016 and later, the Board's findings with regard to whether or not a provider "include[d] in its cost report an appropriate claim for the ***specific*** item [under appeal] (as prescribed in § 413.24(j))"[40] may not be invoked or relied on by the Board to decline jurisdiction. *Instead, 42 C.F.R. § 413.24(j) makes this a requirement for reimbursement*, rather than a jurisdictional one. Nevertheless, when granting EJR, 42 C.F.R. § 405.1873(d)(2) requires the Board to include its specific findings of fact and conclusions of law findings as to whether an appropriate claim was included.

The Board interprets the regulation at 42 C.F.R. § 405.1873 to only require the Board to review a provider's "compliance"[41] 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.[42] The Medicare Contractor filed a Substantive Claim Challenge for two of the four Providers in these cases. With regard to only the Cleveland Clinic, the Group Representative states that it "admittedly did not self-disallow the Fellow Penalty issue in its cost reports for the reporting periods under appeal and stipulates to that fact."[43]

As such, since parties to the appeal (the MAC with regard to Cleveland Clinic and Akron General Medical Center and the Provider with regard to Cleveland Clinic) have questioned, pursuant to § 405.1873(a), whether an appropriate claim was made for two of the four

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[38] (Bold and underline emphasis added.)
[39] 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").
[40] (Emphasis added.)
[41] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[42] *See* 42 C.F.R. § 405.1873(a).
[43] Providers' EJR Requests at 2.

Providers,[44] the Board finds that there is a regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made in the two appeals at issue for those two Providers. The Board notes that because the Provider Cleveland Clinic has stipulated to the fact that it did not self-disallow, and presented its legal arguments and responses with respect to the two Providers, and the MAC had the opportunity to present its arguments, the Board finds that the parties have had an adequate opportunity to submit factual evidence and legal arguments on this issue.

Accordingly, the Board has reviewed these Providers' compliance with 42 C.F.R. § 413.24(j) according to the following procedures set forth in paragraph (3):

> *(3) Procedures for determining whether there is an appropriate cost report claim*. Whether the provider's cost report for its cost reporting period includes an appropriate claim for a specific item (as prescribed in paragraph (j)(1) of this section) must be determined by reference to the cost report that the provider submits originally to, and was accepted by, the contractor for such period, provided that none of the following exceptions applies:
>
> (i) If the provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report, provided that neither of the exceptions set forth in paragraphs (j)(3)(ii) and (iii) of this section applies;
>
> (ii) If the contractor adjusts the provider's cost report, as submitted originally by the provider and accepted by the contractor or as amended by the provider and accepted by the contractor, whichever is applicable, with respect to the specific item, then whether there is an appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the final contractor determination (as defined in § 405.1801(a) of this chapter) for the provider's cost reporting period, provided that the exception set forth in paragraph (j)(3)(iii) of this section does not apply;
>
> (iii) If the contractor reopens either the final contractor determination for the provider's cost reporting period (pursuant to § 405.1885 of this chapter) or a revised final contractor determination for such period (issued pursuant to § 405.1889 of this chapter) and the contractor adjusts the provider's cost report with respect to the specific item, then whether there is an

[44] 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."

> appropriate cost report claim for the specific item must be determined by reference to the provider's cost report, as such cost report claim is adjusted for the specific item in the most recent revised final contractor determination for such period.

a) Findings on Cleveland Clinic's Compliance with § 413.24(j)

Applying that regulation to Cleveland Clinic, Provider No. 36-0180, the cost report that the Provider originally submitted, and was accepted by, the contractor will be referenced to make this determination, as none of the exceptions in the regulation apply to the circumstances of this Provider.[45] Further, in the EJR request, the Provider has stipulated to the fact that it failed to comply with the substantive claim requirement in 42 C.F.R. § 413.24(j).

Based on the above and pursuant to 42 C.F.R. § 405.1873(d)(2), the Board finds in its specific findings of facts and conclusions of law that Cleveland Clinic failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2) in these cases.[46] Cleveland Clinic also requested EJR of its challenge to the validity of substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873. As there are no factual disputes regarding Cleveland Clinic, the Board may consider that challenge as set forth below in Section C below.

b) Findings on Akron General Medical Center's Compliance with § 413.24(j) – Board Majority Only[47]

Applying § 413.24(j)(3) to Akron General Medical Center (Prov. No. 36-0027) ("Akron"), the Board Majority finds that the Provider did not have an appropriate cost report claim for the specific item appealed (*i.e.*, the challenge to the validity of the DGME fellows penalty as applied to Akron).

Akron submitted an as-filed Worksheet E, Part A, on which line 75 lists a protest amount of $6,047,907. The summary of protested amounts submitted with the initial appeal request, indicates a Fellow Penalty Impact amount of $2,505,244, but the total amounts protested add up to $5,975,645 on that spreadsheet instead of $6,047,907 as indicated on Worksheet E. The MAC's Substantive Claim Challenge[48] highlights this discrepancy as a basis for finding that the Provider failed to comply with § 413.24(j).

The Group Representative explained in its response to the Substantive Claim Challenge that the wrong spreadsheet, the one attached to the original as-filed cost report, was uploaded with the initial appeal submission, instead of the corrected one filed with the amended cost report as accepted by the MAC. The Group Representative explained that the most recent amended cost report, as accepted by the MAC, included the total protest amount of $6,047,907, and the spreadsheet that accompanied that amended submission was now being submitted as Exhibit 1, and shows the total amounts protested add up to $6,047,907.

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[45] *See* 42 C.F.R. § 413.24(j)(3).
[46] The Board recognizes that the Group Representative filed a challenge to the regulation at 42 C.F.R. § 413.24(j).
[47] 2 Board members disagree with the findings made in Section B.2.b and have included a dissent attached to the Board decision.
[48] *See supra* note 1 (explaining what the Board's adoption of the term "Substantive Claim Challenge" means).

The Board Majority finds that the amended cost report, as accepted by the MAC, cured the defect alleged by FSS in the Substantive Claim Challenge. As a result, the protested amount in Line 75 of Worksheet E, Part A of the accepted, amended cost report matches the total protested amount included on the summary of protested amounts -- $6,047,907. Further, on that spreadsheet, the Fellow Penalty Impact amount is listed as $2,505,244 and is included in that $6,047,907.

Pursuant to the procedures in 42 C.F.R. § 413.24(j)(3)(i), the Board as the reviewing body is to look to the amended cost report, as accepted by the MAC, for determining "whether there is an appropriate cost report claim for the specific item."[49] "[A]n appropriate cost report claim" is defined in § 413.24(j)(1). Pursuant to 42 C.F.R. § 413.24(j)(1), "in order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, ***the provider's cost report*** . . . *must include* an appropriate claim for the specific item . . . ."[50] This regulatory provision further explains that making "an appropriate claim for the specific item" ***on the cost report*** may be done in two different ways:

> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the provider seeks payment for the item that it believes comports with program policy; or
>
> (ii) Self-disallowing the specific item ***in the provider's cost report***, *if the provider seeks payment that it believes may not be allowable or may not comport with Medicare policy* (for example, if the provider believes the contractor lacks the authority or discretion to award the reimbursement the provider seeks for the item), ***by following the procedures (set forth in paragraph (j)(2) of this section)*** for properly self-disallowing the specific item in the provider's cost report as a protested amount.[51]

Here, Akron claims that it properly self-disallowed the specific item in its cost report consistent with 42 C.F.R. § 413.24(j)(2)[52] which states:

> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must -

[49] In other words, when a provider files an amended cost report and the Medicare contractor accepts it, then the Board must look to the amended cost report rather than the original as-filed cost report to determine if an appropriate cost report claim was made for the specific item. The Board uses the same process for determining whether an appropriate cost report claim by looking to the protested items and worksheet(s) that were included with the as-filed amended cost report.
[50] (Emphasis added.)
[51] (Emphasis added.)
[52] Provider's Response to MAC's Substantive Claim Letters at 1, 6 (June 30, 2022).

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

The Board Majority recognizes that Akron made certain self-disallowances on the amended cost report and that one of these was for the "Fellows Penalty Impact." However, the Board Majority finds that Akron failed to make an appropriate cost report claim for the specific item in these appeals because it failed to satisfy the procedure for self-disallowing as set forth in § 413.24(j)(2). Specifically, the Board Majority understands that § 413.24(j)(2)(ii) requires Akron to attach a worksheet with an estimate of what the "full reimbursement" would be for the "specific self-disallowed item" and describe how that was calculated. Here, that plainly is not the case. The Worksheet for the Fellow Penalty Impact includes multiple statistics from Lines on Worksheet E-4 (*e.g.*, Line 6 of Worksheet E-4) as part of its calculation of the $2,505,244 protested amount. However, those Worksheet E-4 statistics listed thereon do not relate to Akron and, thus, the Worksheet for the Fellow Penalty Impact provided by Akron does not align with an estimate of what the full reimbursement would have been if the issue was allowed using the Worksheet E-4 support that was provided in the jurisdiction documentation for Akron.

Rather, a review of Worksheet E-4 submitted by another participant, Cleveland Clinic Hospital (Prov. No. 36-0180) revealed that the calculation of $2,505,244 (as shown on the Worksheet for the Fellow Penalty Impact) was based on Cleveland Clinic Hospital's filed Worksheet E-4 and not Akron's. For example, the 900.53 FTE's as used in the computation of the Fellow Penalty Impact comes from Worksheet E-4, Line 6 of Cleveland Clinic Hospital cost report. In contrast, Worksheet E-4, Line 6 from Akron's as-filed amended cost report is reported at 134.71 FTEs.[53] That discrepancy is a huge and results in significantly different reimbursement impact related to the fellow penalty. If the correct FTE statistics had been used from Akron's cost report then the reimbursement impact would have been just $72,951.35 (in contrast to the $2.5 million plus listed on the Worksheet for the Fellow Penalty Impact).[54] Accordingly, the Board Majority finds

[53] The Worksheet attached to the as-filed and accepted amended cost report (as required by § 413.24(j)(2)(ii)) clearly appears to pertains to the Cleveland Clinic Hospital (Prov. No. 36-0180) and not to Akron (Prov. No. 36-0027). First, the header to the Worksheet lists it as pertaining to "Cleveland Clinic Hospital Provider No. 360180." More importantly, consistent with the header, the data identified in the Worksheet as being from Lines on Worksheet E-4 clearly pertained to the Cleveland Clinic Hospital. For example, the 900.53 FTEs were listed on the Worksheet as being from Worksheet E4, Line 6 and, per the header, this is consistent with the copy of the Worksheet E4 included for the Cleveland Clinic Hospital that shows 900.53 FTEs on its Worksheet E4, Line 6.

[54] While the amount in controversy calculation (AiC) filed in these appeals for Akron is ***not*** relevant to whether an appropriate cost report claim was made for the specific item that Akron appealed in these cases (since it was not part of the as-filed amended cost report at issue), it does highlight how the calculation in the Worksheet for the Fellow Penalty Impact (as attached to the as-filed amended cost report at issue) was materially incorrect. Specifically, the AiC calculation filed for Akron in these appeals used the correct FTE statistics from Akron's Worksheet E-4 and shows that these appeals involve an AiC of $72,951.35 for Akron.

that the Provider failed to provide a good faith estimate of the specific self-disallowed item as required in § 413.24(j)(ii).[55] Further, the Board majority finds that DGME fellow penalty was not properly self-disallowed when the Fellow penalty calculation was based on Cleveland Clinic cost report data and not Akron's cost report data.

In support of its position, the Board Majority refers to the preamble discussion in the proposed and final rules that adopted § 413.24(j). For example, the following excerpt makes clear that the protested amount should be for the particular Provider and be a claim for its costs:

> Upon further reflection, . . . we determined that the requirement that a provider either claim reimbursement for a specific cost, or *expressly self-disallow* ***the cost***, in its cost report is more appropriately treated as a cost reporting requirement under sections 1815(a) and 1833(e) of the Act, *as the agency cannot make payments to a provider* ***without sufficient information*** *on all claims for which the provider believes it should be paid*. Indeed, it is eminently reasonable for the Secretary to require a provider to make an appropriate cost report claim for a specific item if the provider wants to be paid for the item. As we explain in detail in the next section, *requiring a cost report claim for* ***full*** *reimbursement* ***or*** *an express self-disallowance of the cost* ***enables the contractor to review and audit the claim, make any adjustments that seem appropriate, and include any final payment for the cost as part of the NPR***. Accordingly, in the FY 2015 IPPS/LTCH PPS proposed rule (79 FR 28209 through 28212 and 28306 through 28307), we proposed to revise the cost reporting regulations in Part 413, Subpart B by adding the substantive reimbursement requirement that a provider must include an appropriate claim for an item in its cost report. We proposed that ***the failure to account appropriately for the item*** *in the provider's cost report* would foreclose payment for the item in the NPR issued by the contractor and in any decision, order, or other action by a reviewing entity (as defined in § 405.1801(a) of the regulations) in an administrative appeal filed by the provider.[56]

In summary, the Worksheet for the Fellow Penalty Impact attached to the amended cost report failed to comply with § 413.24(j)(2)(ii) and include a proper estimate of the specific item for

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[55] *See* 42 C.F.R. § 413.24(a) (principle that providers receiving payment on the basis of reimbursable cost must provide adequate cost data); 42 C.F.R. § 413.24(c) (addressing adequacy of cost information). The fact that the MAC accepted the amended cost report has nothing to do with the Board's obligation under 42 C.F.R. § 405.1873(b) to determine whether an appropriate cost report claim was, in fact made, *for the specific item appealed* when a party questions whether the Provider so complied. Similarly, the fact that the MAC removed the DGME Fellows protest item as a nonallowable item in Audit Adjustment No. 13 (which is described as "To remove protested amount related to IME (fellow penalty)") has no bearing on the Board's obligation to determine whether an appropriate cost report claim was, in fact, made *for the specific item appealed*. Finally, regardless of whether the methodology used to calculate the estimate required under 42 C.F.R. § 413.24(j)(2)(ii) was correct, the fact remains that the data and statistics used *in that methodology* was clearly incorrect and did ***not*** pertain to Akron.

[56] 80 Fed. Reg. 70298, 70554 (Nov. 13. 2015) (emphasis added).

which reimbursement is now sought on appeal before the Board. Accordingly, the Board finds that the Provider failed to include an "appropriate cost report claim for the specific item" as required by § 413.24(j)(3)(i). Taken all together, the documentation submitted is insufficient to show that the requirements of 42 C.F.R. § 413.24(j) have been met as the protested item was not for Akron.

Finally, the Board Majority recognizes that, in its response to the MAC's substantive claim challenge, Akron asserts that it also was not required to comply with 42 C.F.R. § 413.24(j) because it is unlawful and invalid.[57] However, the Board Majority does not reach this issue because there was a factual dispute that needed resolution and, as such, EJR was inappropriate as it relates to Akron.

c) No Findings on Compliance with § 413.24(j) Required for the Remaining Providers – Hillcrest Hospital and Fairview Hospital

Since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made by the other two Providers, specifically, Hillcrest Hospital and Fairview Hospital,[58] the Board finds that there is no regulatory obligation for the Board to affirmatively, on its own, review the appeal documents to determine whether an appropriate claim was made for these two Providers. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for these two Providers. Accordingly, the Board will proceed to rule on the EJR requests pursuant to 42 C.F.R. § 405.1873(d).

C. EJR Request on the Validity of 42 C.F.R. §§ 413.24(j)

While the Provider Cleveland Clinic plainly admits that it did not protest the DGME fellows issue on its cost reports, the Provider also asserts that the self-disallowance regulation at 42 C.F.R. § 413.24(j) is invalid. Moreover, the Provider's Representative simultaneously requested EJR over the validity of 42 C.F.R. §§ 413.24(j) in addition to the DGME fellow penalty issue (discussed more fully, below).[59]

In the EJR request, the Provider asserts that the self-disallowance regulation at 42 C.F.R. 413.24(j)(1)(ii) is unlawful insofar as it requires providers to expressly self-disallow claims for payment that they believe are not allowable under Medicare policy, even if such claims are futile because the MACs have no authority to allow them.[60] Moreover, this requirement, which previously was for a jurisdiction requirement instead of a payment requirement, has been struck down by the Courts, citing *Bethesda Hospital Association v. Bowen*[61] and *Banner Heart Hospital v. Burwell*.[62] The Provider asserts that while the Board retains jurisdiction to hear the appeals of providers that have not complied with the self-disallowance regulation, the regulation strips the Board of its power to "affirm, modify or reverse a final determination of the" MAC as Congress

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[57] Providers' Response to MAC's Substantive Claim Letters, at 2 (June 30, 2022).
[58] Board Rule 10.2 provides that "[i]f 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."
[59] Provider's EJR Requests at 1-2, 10-15, 17-21.
[60] *Id.* at 2, 13-14.
[61] 485 U.S. 399 (1988).
[62] 201 F.Supp.3d 131 (D.D.C. 2016); *see* Provider's EJR Request at 2, 11-13, 17-18.

granted in 42 U.S.C. § 1395oo(d).[63] Stated another way, the Provider asserts that "the Board must hear providers' appeals, but it is powerless to pay them."[64]

Even though Cleveland Clinic acknowledges that it did not self-disallow the fellow penalty in its cost reports in these two cases, as required by 42 C.F.R. § 413.24(j), the Provider asserts that it is nonetheless entitled to payment because that regulation is unlawful. In support of this contention, the Provider outlines several arguments, including that the self-disallowance regulation is contrary to the statute at 42 U.S.C. § 1395oo and that it is arbitrary and capricious because CMS has provided no explanation as to why the agency needs providers to present this information at the time they submit their cost reports.[65]

With regard to the Board's jurisdiction, the Provider points to 42 U.S.C. § 1395oo(f)(1), which allows a provider to obtain judicial review "of any action of the fiscal intermediary which involves a question of law or regulations relevant to the matters in controversy whenever the Board determines (on its own motion or at the request of a provider of services as described in the following sentence) that it is without authority to decide the question."[66]

Per 42 C.F.R. § 405.1842(a)(1), "a provider the right to seek EJR of a legal question relevant to a specific matter at issue in a Board appeal if there is Board jurisdiction to conduct a hearing on the matter." Here, the challenge made by Cleveland Clinic regarding the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is relevant to the matter at issue in this group appeal.[67] Since there is no factual dispute regarding the Provider's lack of compliance with 42 C.F.R. § 413.24(j), the Board is able to reach consideration of Cleveland Clinic's challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873. Further, 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 provisions that create the self-disallowance requirements in §§ 413.24(j) and 405.1873, which is the remedy the Provider is seeking. Consequently, EJR is appropriate on this issue and the Board hereby, grants the Provider's EJR request on that challenge.

D. Board's Analysis of the DGME Fellows Penalty Issue

The Provider asserts 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 Provider asserts that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a

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[63] *Id.* at 13-14, 17.
[64] *Id.*
[65] *Id.* at 17-21.
[66] *Id.* at 21-22.
[67] The Board recognizes that this question relates only to Cleveland Clinic and does not apply to the full group and that, as a result, it would appear to run afoul of 42 C.F.R. § 405.1837(g) and potentially require bifurcation. However, the Board finds that this is not so in this case. Compliance with 42 C.F.R. § 413.24(j) is substantive in nature (*i.e.*, directly impacts potential reimbursement), but does not affect the issue that is the subject of the appeal. Similar to jurisdictional review, a provider's compliance with § 413.24(j) relates to the nature of the provider's participation in the group (as set forth in 42 C.F.R. § 405.1873) and is only triggered when, pursuant to § 405.1873(a) as a procedural matter in the proceedings before the Board, a party raises their hand and questions the provider's compliance with § 413.24(j). As a result, the Board finds that potential bifurcation has not been triggered under § 405.1837(f). This situation is akin to the Board denying jurisdiction over one participant in a group but granting EJR relative to the rest of the group. Accordingly, judicial review is available to Cleveland Clinic.

particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows.

$$\text{Allowable FTE count} = \text{Weighted FTE Count x} \left(\frac{\text{Unweighted FTE Cap}}{\text{Unweighted FTE Count}}\right)$$ [68]

Accordingly, the Board sets out to confirm the Provider's 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.[69] 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.[70] 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].[71]

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[68] EJR Requests at 5-10, 15-17.
[69] *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.)).
[70] 66 Fed. Reg. at 39894 (emphasis added).
[71] (Emphasis added.)

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.[72] 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."[73] 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[74] (*i.e.*, ratios) using variables a, b, c, and d:

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

On the 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.[75]

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:

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

[73] *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.)).

[74] 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.

[75] 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.

$$\textbf{Weighted FTE cap} = \frac{Unweighted\ FTE\ Cap}{FY's\ Unweighted\ FTE\ Count} \times FY's\ Weighted\ FTE\ Count$$

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 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.

Board's Decision Regarding the EJR Requests

The Board makes the following findings regarding Case Nos. 19-0823GC and 19-0824GC[76]:

1) It has jurisdiction over both the DGME Penalty Issue in these cases ***and*** the challenge made therein by Cleveland Clinic to the validity of 42 C.F.R. §§ 413.24(j) for the subject years and that the Providers in these appeals are entitled to a hearing before the Board;

2) The Providers appealed cost reporting periods beginning after January 1, 2016 makes the following findings on two participants pursuant to 42 C.F.R. § 405.1873(b):

    a. It is undisputed that Cleveland Clinic (Provider No. 36-0180) failed to include "an appropriate claim for the specific item" that is the subject of the two appeals, as required under 42 C.F.R. § 413.24(j), and

    b. Akron General Medical Center did not make "an appropriate claim for the specific item" that it appealed in these two appeals (finding in Section B.2.b by Board Majority only[77]);

3) Based upon the Providers' assertions regarding 42 C.F.R. § 413.79(c)(2)(iii), as well as the assertions regarding the validity of 42 C.F.R. §§ 413.24(j), 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

[76] The Board recognizes that the providers in Case No. 19-0823GC and 19-0824GC are the same and that, in each case, the providers are challenging the same regulatory language with the only difference being its application to the current year versus the prior and penultimate years. For purposes of administrative ease, the Board did not consolidate Case No. 19-0823GC and 19-0824GC into a single group even though the groups appealed the same issue. Due to the fact that these cases are being dispensed in the same consolidated EJR and no further proceedings before the Board will occur, the Board opted not to consolidate into one group prior to issuing this EJR determination even though it is treating it as one CIRP group.

[77] *See supra* note 47.

5) It is without the authority to decide the legal questions of whether 42 C.F.R. § 413.79(c)(2)(iii) is valid ***and***, with respect to Cleveland Clinic, whether the regulation at 42 C.F.R. §§ 413.24(j) is valid.

Accordingly, the Board finds that the questions in Finding No. 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' requests for EJR. 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 two appeals, the Board hereby closes them and removes them from the Board's docket.

Board Members Participating:

Clayton J. Nix, Esq.
Gregory H. Ziegler, CPA
Robert A. Evarts, Esq. (dissenting in part)
Kevin D. Smith, CPA (dissenting in part)
Ratina Kelly, CPA

FOR THE BOARD:

7/29/2022

X Clayton J. Nix

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

Enclosure - Schedule of Providers for Case Nos. 19-0823GC, 19-0824GC
Opinion Dissenting in Part (4 pages)

cc: Judith Cummings, CGS Administrators
Wilson C. Leong, FSS

Opinion Dissenting in Part

EJR Determination in:

- Case No. 19-0823GC - Cleveland Clinic Health CY 2016 DGME Fellow Penalty Present Year CIRP
- Case No. 19-0824GC - Cleveland Clinic Health CY 2016 DGME Fellow Penalty Prior & Penultimate Yrs. CIRP

Robert A. Evarts, Esq., Member and Kevin D. Smith, CPA, Member, dissenting in part as it relates to Section B.2.b

We concur in the Board Majority decision except for the findings made in Section B.2.b. We find that Akron General Medical Center ("Akron") complied with § 413.24(j) because, unlike the Board Majority, we find that Akron made an appropriate claim for the DGME fellow penalty issue.

Applying § 413.24(j)(3) to Akron (Prov. No. 36-0027), the Board Minority finds that the Provider has an appropriate cost report claim for the DGME fellow penalty issue because, as set forth below, it met the exception in § 413.24(j)(i).

Akron General Medical Center submitted an as-filed Worksheet E, Part A, on which line 75 lists a protested amount of $6,047,907. The summary of protested amounts submitted with the initial appeal request, indicates a Fellow Penalty Impact amount of $2,505,244, but the total amounts protested add up to $5,975,645 on that spreadsheet instead of $6,047,907 as indicated on Worksheet E, Part A. The MAC's Substantive Claim Challenge[1] highlights this discrepancy as its only basis for finding that the Provider failed to comply with § 413.24(j).

The Group Representative explained in its response to the Substantive Claim Challenge that the wrong spreadsheet, the one attached to the original, as-filed, cost report, was uploaded with the initial appeal submission, instead of the corrected one filed with the amended cost report. The MAC accepted both the original, as-filed, cost report and the amended cost report. The Group Representative explained that the amended cost report, as accepted by the MAC, included the total protested amount of $6,047,907, and the spreadsheet that accompanied that amended submission was now being submitted as Exhibit 1 to the appeal, and shows the total protested amounts add up to $6,047,907.

The Board Minority agrees with the Board Majority in finding that the amended cost report, as accepted by the MAC, cured the defect alleged by FSS in the Substantive Claim Challenge. As a result, the protested amount in Line 75 of Worksheet E, Part A of the accepted, amended cost report reconciles to the total protested amount included on the summary of protested amounts – $6,047,907. Further, on that spreadsheet, the Fellow Penalty Impact amount of $2,505,244 is clearly identified and included in the $6,047,907.

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[1] *See supra Majority* note 1 (explaining what the Board's adoption of the term "Substantive Claim Challenge" means).

However, the Board Minority disagrees with the Board Majority's position that Akron failed to submit an appropriate cost report "claim" for the Fellow Penalty.[2] The Majority believes that, because the Worksheet attached to Akron's accepted as-filed and amended cost reports identifies "Cleveland Clinic Hospital" at the top of the page, and the data on the Worksheet reflects Cleveland Clinic Hospital data, there is not a valid "claim" for the Fellow Penalty issue.[3] However, the Board Minority concludes that the "claim" is established by the cost report, not a worksheet. This conclusion is supported by the fact that the MAC recognized the Fellow Penalty claim in both the as-filed and amended, cost reports. Support for this conclusion is also found in Section 115 of CMS Pub. 15-2 (the "Cost Reporting Instructions"), "COST REPORTS FILED UNDER PROTEST" which states, "Include the nonallowable item in the cost report in order to establish an appeal issue, and the disputed item must pertain to the cost reporting period for which the cost report is filed." Akron included the Fellow Penalty, a "nonallowable item" on its amended cost report which was accepted by the MAC. Further, § 115.2 of the Cost Reporting Instructions, places the duty upon the MAC to "evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable."[4] Assuming that the MAC complied with this requirement, Akron's methodology for completing its amended cost report, was reasonable.

As such, the Board Minority finds that an appropriate cost claim was made for the DGME fellow penalty issue because the Provider qualifies for the exception under § 413.24(j)(3)(i), which states, in pertinent part:

> If a provider submits an amended cost report for its cost reporting period and such amended cost report is accepted by the contractor, then whether there is an appropriate cost report claim for the specific item must be determined by reference to such amended cost report. . . .

Here, the Medicare Contractor accepted both the originally filed and the amended cost reports of the Provider. As discussed above, the protested amount on this amended, accepted cost report was supported by a worksheet summarizing the three protested items, one of which identifies the issue as a "Fellow Penalty Impact" in the amount of $2,505,244. A calculation of this amount, showing the Provider's methodology is also included. The Medicare Contractor specifically adjusted off the DGME Fellows protested item in Audit Adjustment No. 13, in the amount of $2,505,244, which is described as "To remove protested amount related to IME (fellow penalty)." Accordingly, the Board Minority finds that the Provider meets the exception in § 413.24(j)(3)(i) because a claim was made on Worksheet E, part A, Line 75 in the amount of $6,047,907, which included the $2,505,244 associated with the Fellow Penalty. The total amount of $6,047,907, which included the $2,505,244 associated with the Fellow Penalty, was removed from the amended cost report in 3 adjustments, reconciling to the three issues being protested.

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[2] *See,* Section B.2.b.
[3] *Id.*
[4] Cost Reporting Instructions, ¶ 115.2.

Further, the Board Minority notes that Section 115 of the Cost Reporting Instructions begins, "[y]ou are permitted to dispute regulatory and policy interpretations through the appeals process established by the Social Security Act. Include the nonallowable item in the cost report in order to establish an appeal issue. . . ." Section 115.2 of the Cost Reporting Instructions continues, "you must submit, with the cost report, copies of the working papers used to develop the estimated adjustments in order for the contractor/contractor [sic] to evaluate the reasonableness of the methodology for purposes of establishing whether the cost report is acceptable." The Board Minority notes that the Medicare Contractor accepted both the original and the amended cost reports, thus evidencing their determination that Akron's methodology was reasonable.

The Board Minority also finds support for its position in the preamble discussion in the proposed and final rules that adopted § 413.24(j). For example, the following excerpt reflects the duty of the MAC to assess the adequacy of the cost report claim for a self-disallowed item:

> Upon further reflection, . . . we determined that the requirement that a provider either claim reimbursement for a specific cost, or *expressly self-disallow* ***the cost***, in its cost report is more appropriately treated as a cost reporting requirement under sections 1815(a) and 1833(e) of the Act, as the agency cannot make payments to a provider without sufficient information on all claims for which the provider believes it should be paid. . . . As we explain in detail in the next section, requiring a cost report claim for full reimbursement or *an express self-disallowance of the cost* ***enables the contractor to review and audit the claim, make any adjustments that seem appropriate, and include any final payment for the cost as part of the NPR***.[5]

The need to amend a provider's cost report is also recognized by the preamble language when it states, "There may be instances where a provider learns of new and material information or needs to correct an error after filing the cost report, and in such situations, the provider may submit an amended cost report or request that the cost report be reopened."[6] Clearly, Akron only recognized, when FSS raised a substantive claim challenge, that the wrong worksheet had been attached to its cost reports. However, this oversight was due to the MAC's dereliction of its duty to review and accept only cost reports that were adequate for the self-disallowed items therein. Akron should not be penalized for the MAC's failure to complete its duty to review and approve submitted cost reports.

Finally, the Board Minority recognizes that, in its response to the MAC's substantive claim challenge, Akron asserts that it also was not required to comply with 42 C.F.R. § 413.24(j) because it is unlawful and invalid.[7] However, the Board Minority does not reach this issue because it has found that Akron has complied with its substantive claim obligations under 42 C.F.R. § 413.24(j) by submitting an appropriate, self-disallowed, claim for the Fellow Penalty.

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[5] 80 Fed. Reg. 70298, 70554 (Nov. 13. 2015) (emphasis added).
[6] *Id.* at 70562.
[7] Providers' Response to MAC's Substantive Claim Letters, at 2 (June 30, 2022).

Board Members Participating:
Robert A. Evarts, Esq.
Kevin D. Smith, CPA

FOR THE BOARD:

7/28/2022

X Robert A. Evarts, Esq.

Robert A. Evarts, Esq.
Board Member
Signed by: Robert A. Evarts -A