DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert L. Roth, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
HCA FFY 2020 Area Wage Index Standardized Amount Reduction CIRP Group
Case No. 21-0218GC

Dear Mr. Roth:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' June 10, 2022 request for expedited judicial review (EJR) in the above referenced appeal. After the Medicare Administrative Contractor requested additional time to respond on June 13th,2022, the Board issued a scheduling order on June 29th, giving the MAC until July 7th to provide comments on jurisdiction, substantive claim and EJR. As jurisdiction is a prerequisite to consideration of an EJR request,[1] the Scheduling Order necessarily affected the 30-day period for the Board's determination of authority required to decide the EJR request. To date, no comments have been received, and the deadline has since passed. The Board's decision on jurisdiction and EJR is set forth below.

The issue for which EJR has been requested is:

> [W]hether the Hospitals' FFY 2020 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2016% for FFY 2020.[2]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[3] known as the Inpatient Prospective Payment System (IPPS). Under IPPS, Medicare payments

[1] 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 request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision." Including documentation and information related to challenges 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).
[2] Providers' EJR requests at 1.
[3] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). The base payment rate is comprised of a standardized amount[4] for all subsection (d) hospitals located in an "urban" or "rural" area.[5]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E), requires that, the Secretary[6] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas ("CBSAs") established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10) .[7]

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[8]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[9] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information

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[4] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

[5] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

[6] of the Department of Health and Human Services.

[7] https://cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/wage.

[8] *Id.*

[9] 83 Fed. Reg. 20164 (May 7, 2018).

("RFI") as part of the FFY 2020 IPPS proposed rule.[10] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[11] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[12]

In the FY 2020 IPPS final rule, the Secretary summarizes its proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[13]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[14] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals,

[10] 84 Fed Reg 19158, 19393-94 (May 3, 2019)).
[11] *Id.*
[12] *Id.*
[13] 84 Fed. Reg. at 42326 (citations omitted).
[14] *Id.* at 42328.

hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[15]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[16] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[17]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[18] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[19]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that, while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not

[15] *Id.* at 42326
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.* at 42326-7

considered high or low, do not have their wage index values affected by this proposed policy."[20] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . .it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[21]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[22]. Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[23] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84FR19672), were are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[24]

Providers' Position:

The Providers are challenging their IPPS payments for 2020 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the wage index values of hospitals with an average wage index (AWI) in the lowest quartile. The Providers explain that, in the FFY 2020 IPPS final rule, the Secretary sought to address what he called "wage index disparities" by adopting a number of new policies that impacted the AWI values and IPPS reimbursement hospitals receive. One of the policies increases the AWI values of hospitals with an AWI in the lowest quartile nationally ("AWI subsidy"). The Providers contend that the AWI subsidy increased the AWI values of hospitals with AWI values in the lowest quartile by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values. Further, the Providers note, the Secretary asserted that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E). This section of the statute authorizes the Secretary to adjust the labor-related portion of hospital payments to account "for area differences in hospital wage levels by a factor (established by the Secretary)

[20] *Id*. at 42329
[21] *Id at 42328-9.*
[22] *Id.* at 42331.
[23] *Id*.
[24] *Id*.

reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level."

Further, the Providers allege issues with the Secretary's election to implement the new AWI Subsidy in a budget neutral manner. Specifically, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2016 percent to offset the AWI increases to those hospitals in the lowest AWI quartile. The Providers point out that the Secretary asserts that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E) and that, even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke his statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment. This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate."

The Providers argue that the Secretary lacks the authority, under his "exceptions and adjustment" authority under 42 U.S.C. § 1395ww(d)(3)(E), or otherwise in order to establish the AWI subsidy in the manner set forth in the FFY 2020 Final IPPS Rule. Similarly, the Provider argue that, even if he had lawfully established such a subsidy, he cannot lawfully reduce the standardized amount in the manner that he did as part of his implementation of the AWI Subsidy. Consequently, the Providers are challenging the reduction of the standardized amount on several grounds, including, but not limited to, that: (1) it exceeds statutory authority; (2) it contradicts the AWI congressional mandated; (3) it was developed in an arbitrary and capricious manner; (4) it lacks support from substantial evidence; and (5) it is otherwise defective both procedurally and substantively. The Providers further contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

Accordingly, the Providers maintain that EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, and the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2016 percent reduction issued by the Secretary in the FFY 2020 IPPS final rule.

Decision of the Board:

The participants that comprise the group appeal within this EJR request have filed an appeal involving FFY 2020 based on their appeal from the FFY 2020 IPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in this CIRP group appealed from the FFY 2020 IPPS Final Rule.[25] The Board has determined that (1) the participants' documentation shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[26] (2) the appeals were timely filed as direct adds to the group; and (3) the group contains a single issue that is not precluded by statute or regulation from administrative and judicial review. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeal 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. Application of 42 C.F.R. § 405.1873

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

[25] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015) [30] *See* 42 C.F.R. § 405.1837.

[26] *See* 42 C.F.R. § 405.1837.

> 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.[27]

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.
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> (b) *Summary of Procedures*.
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> ***
>
> (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-*

[27] (Bold and underline emphasis added.)

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> (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). . . .[28]

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 this CIRP group are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[29] The regulation at 42 C.F.R. § 405.1873 dictates that, for fiscal years beginning on or after January 1, 2016, 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))"[30] 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"[31] 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.[32] However, the Board notes that § 405.1873(b) has not been triggered because neither party has questioned whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal, presumably because any such potential issue is not yet ripe. In this regard, the Board notes that the participants appealing the FFY 2020 Federal Register Notice and the cost

[28] (Bold and underline emphasis added.)
[29] 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").
[30] (Emphasis added.)
[31] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[32] *See* 42 C.F.R. § 405.1873(a).

reports impacted by such notice have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[33]

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment of 0.2016 to the FFY 2020 national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[34] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals],including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[35] and

2. "[A]addressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that

[33] *See* 80 Fed. Reg. at 70556, 70569-70.
[34] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals.
[35] *Id.* at 42326.

> budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule. . .we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[36]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[37]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to by the Uncodified Regulation on Wage Index published in the FFY 2020 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount by 0.2016 for FFY 2020. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal 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 year and that the participants in this group appeal are entitled to a hearing before the Board;

2) Based upon the participants' assertions regarding the FFY 2020 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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[36] 84 Fed. Reg. at 42331.

[37] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

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 the Uncodified Regulation on Wage Index published in the IPPS 2020 Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Rural Reclassification as published in the FFY 2020 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the case, the Board hereby closes the case.

Board Members Participating:

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

FOR THE BOARD:

8/1/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Pam VanArsdale, NGS
Cecile Huggins, Palmetto GBA
Laurie Polson, Palmetto GBA c/o NGS
Danene Hartley, NGC
Byron Lamprecht, WPS
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Doug Lemieux
Centura Health
9100 East Mineral Cir., Ste. 300
Centennial, CO 80112

RE: ***Notice of Dismissal***
St. Mary Corwin Medical Center (Prov. No. 06-0012)
FYE 6/30/2014
Case No. 17-1464

Dear Mr. Lemieux:

The Provider Reimbursement Review Board ("Board" or "PRRB") received St. Mary Corwin Medical Center's ("Provider") Individual Appeal Request on appeal on March 10, 2017, appealing from a Notice of Program Reimbursement ("NPR") dated November 11, 2016. The sole issue remaining is "Distinct Part Rehab Outlier Reconciliation." The Provider filed a Preliminary Position Paper ("PPP") on December 22, 2017, and the Medicare Contractor filed its PPP on April 30, 2018.

On March 25, 2020, the Board issued Board Alert 19 announcing temporary adjustment to the Board's processes in light of the Covid-19 public health emergency. Among other things, Board Alert 19 suspended Board-set deadlines from March 13, 2020 forward and "encourage[d] Providers and their representatives to continue to make these filings ***electronically*** through OH CDMS, as appropriate and in keeping with public health precautions."[1] Board Alert 19 remains in effect.

The Board issued a Notice of Hearing on June 24, 2021 which set a due date for Provider's Final Position Paper ("FPP") of January 26, 2022 and set a hearing date for April 26, 222. However, the Provider was never filed the FPP. On April 7, 2022, the Board Advisor reached out to the parties to request an update on whether the Provider was still pursuing its case since it has not filed its FPP. The e-mail correspondence was returned as undeliverable to the Provider's designated representative (the Provider's Corporate Reimbursement Director). As a courtesy, the Board Advisor forwarded the request for an update to Christopher Craig, who is listed as the primary contact for Centura Health, which is the Provider's parent organization, but that e-mail correspondence was also returned as undeliverable. As an additional final courtesy, the Board Advisor called the phone number listed in OH CDMS for the Provider's designated representative, and was advised that he is no longer listed in their system, and that there was no one listed as the Corporate Reimbursement Director.

[1] (Emphasis in original.)

The Board has not received any correspondence or communication from the Provider or its Representative since it filed is preliminary position paper ("PPP") on December 22, 2017. In particular, the Board has not received any correspondence to update the Board on the status of the case in response to the Board inquiry.

Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

- ***if it has a reasonable basis to believe that the issues have been fully settled or abandoned***,
- upon failure of the provider or group to comply with Board procedures or filing deadlines,
- ***if the Board is <u>unable</u> to contact the provider or representative at the last known address, or***
- ***upon failure to appear for a scheduled hearing***.[2]

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

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

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

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

[2] (Emphasis added.)

> (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.

Further, Board Rule 5.2 addresses the Representative's responsibilities:

> The case representative is responsible for being familiar with the following rules and procedures for litigating before the Board:
>
> - The Board's governing statue at 42 U.SC. §139500;
> - The Board's governing regulations at 42 C.F.R. Part 504, Subpart R; and
> - These rules, which include any relevant Orders posted at https://www.cms.gov/Regulations-and-Guidance/Review-Boards/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.

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

> The regulations give the Board broad authority and flexibility to establish procedures. The regulation at 42 C.F.R. § 405.1853 directs the parties to expeditiously attempt to both resolve specific factual or legal issues and reach stipulations. To give the parties maximum flexibility and for judicial economy, the parties may choose one of the following prehearing scheduling options:

- Agree to a proposed joint scheduling order, which is a detailed prehearing schedule setting timeframes for prehearing activities (such the exchange of documentation) and culminating with a deadlines for the parties to file preliminary position papers. The Board will not track any deadlines that occur prior to the deadlines for filing the preliminary position papers. Further, unless the parties expressly and jointly waive them, the Board will establish filing deadlines for optional final position papers based on the actual hearing date, *see* Rule 27. The PJSO is based on the parties' analysis of the development needed for the case. The PJSO is subject to Board approval. (*See* Rule 24),
- If the parties do not elect the JSO process, file a preliminary position paper and follow the timelines established by the Board in its acknowledgement letter.

Upon receiving an appeal request, the Board will send an acknowledgement letter establishing the filing due dates. By the first filing date, the parties file with the Board either a PJSO or a preliminary position paper.

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

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

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

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

[3] (Emphasis added.)

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

While Board Alert 19 suspended Board-set deadlines, providers continue to have responsibilities related to their appeals, including but not limited to ensuring that their contact information is current. Based on the inability of the Board to contact the Provider's Representative through any of the methods of contact on file (both email and telephone), the apparent failure of the Provider to maintain current contact information in accordance with Board Rule 5.2, and the lack of any contact with the Board since filing its PPP on December 22, 2017 (including, but not limited to, responding to the Notice of Hearing and failing to appear to the scheduled hearing), the Board hereby dismisses Case No. 17-1464 and removes it from its docket pursuant to its authority under 42 C.F.R. § 405.1868(b).

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

Board Members:

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

For the Board:

8/1/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq. Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Jessica Cappa
Osceola Regional Medical Center
700 West Oak St.
Kissimmee, FL 34741

RE: ***Notice of Dismissal***
Osceola Regional Medical Center (Prov. No. 10-0110; FFY 2020)
Case No. 20-1258

Dear Ms. Cappa,

Pursuant to the Notice of Hearing and Critical Due Dates issued the Provider Reimbursement Review Board ("Board") on January 13, 2022, the Provider's preliminary position paper was due June 24, 2022 and the hearing was set for September 22, 2022. However, the Provider failed to file its PPP by the June 24, 2022 due date and, to date, has yet to make this filing. On July 19, 2022, as the Provider's Representative in this case, you stated via e-mail that the Provider was no longer pursuing the case (see attached). In response, you were asked to submit a formal withdrawal through OH CDMS to document your request in the record. To date, you have taken no further action or communication since the July 19, 2022 email.

On July 26, 2022, Stacey Hayes of WPS Government Health Administrators requested on behalf of the Medicare Administrative Contractor ("MAC") for the Provider Reimbursement Review Board ("Board") to dismiss the case and included, as an exhibit, the July 19, 2022 email in which you stated that the Provider was no longer pursuing the case. To date, you have taken no action to respond to the MAC's request.

In accordance with Board Rule 41.2, the Board may dismiss a case if it has a reasonable basis to believe that the issues have been fully settled or abandoned. Based on the above findings, the Board concludes that the Provider has abandoned the appeal and dismisses the appeal pursuant to its authority under 42 C.F.R. § 405.1868(a)-(b) and Board Rule 41.2. Accordingly, the Board closes the case and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/1/2022

X Clayton J. Nix

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

Enclosure: E-mail from Jessica Cappa (2 pages)

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Bill Tisdale
Novitas Solutions, Inc. (J-H)
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Baptist Health System (Prov. No. 45-0058)
FYE 08/31/1997
Case No. 15-0444

Dear Messrs. Ravindran and Tisdale,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background:

The Provider was issued a Notice of Reopening on August 7, 2013,[1] in which it was advised that the cost report was being reopened "[t]o adjust the Provider's SSI% to agree with the SSI% recalculated by CMS using MedPar data for the Provider's cost reporting period ending 08/31/97."[2] Subsequently, the Medicare Contractor issued the Notice of Amount of Corrected Reimbursement ("RNPR")[3] on May 22, 2014.[4]

Baptist Health System ("Baptist" or "Provider") filed its individual appeal request from the RNPR on November 18, 2014,[5] to which the Board assigned Case No. 15-0444. The RNPR appeal included four (4) issues:

DSH SSI Percentage (Provider Specific)
DSH SSI (Systemic Errors)
DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]

[1] Medicare Contractor's Notice of Reopening Cost Report.
[2] *Id.*
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] MAC's Notice of Program Reimbursement Reopening Settlement #4.
[5] Provider's Request for Individual Appeal, at Model Form A.
[6] *Id.*, at Issue Statement.

The Provider referenced audit adjustment #4 for all four issues appealed from the RNPR. Adjustment #4 was issued to adjust the SSI% and the Disproportionate Share Amount based on the latest CMS letter of SSI% Realignment.[7]

Board Determination:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2014), a provider has a right to a hearing before the Board with respect to 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 (or $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 RNPR at 42 C.F.R. § 405.1885 (2014), 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 (2014)[8] 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.

[7] Audit Adjustment Report.
[8] *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).

As set forth below, the Board finds that it does not have jurisdiction over the four issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request pursuant to 42 C.F.R. § 412.106(b)(3).[9] As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[10] 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
>
> (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

[9] 42 C.F.R. § 412.106(b)(3) provides that "*[i]f a hospital prefers that CMS use its cost reporting period* ***instead of the Federal fiscal year***, it must furnish to CMS, through its intermediary, a written request including the hospital's name, provider number, and cost reporting period end date. This exception will be performed once per hospital per cost reporting period, and the resulting percentage becomes the hospital's official Medicare Part A/SSI percentage for that period." (Emphasis added.)

[10] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[11]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[12] 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***."[13]

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."[14]

---

[11] (Emphasis added.)
[12] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[13] (Emphasis added.)
[14] (Emphasis added.)

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 DSH SSI Percentage (Provider Specific), DSH SSI (Systemic Errors), DSH Payment – SSI Fraction/Medicare Managed Care Part C Days, and the DSH Payment – SSI Fraction/Dual Eligible Days issues in the individual appeal. 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.[15]

In conclusion, the Board ***dismisses*** the four issues appealed from the RNPR in Case No. 15-0444 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 15-0444 and removes it from the Board's docket.

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

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

FOR THE BOARD:

8/2/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

[15] *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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Provider Reimbursement Review Board
7500 Security Boulevard
Mail Stop: N2-19-25
Baltimore, MD 21244
410-786-2671

Via Electronic Delivery

Maureen O'Brien Griffin, Esq.
Hall, Render, Killian, Heath & Lyman, P.C.
500 N Meridian St. #400
Indianapolis, IN 46204

Byron Lamprecht
WPS Government Health Administrators
2525 N 117th #200
Omaha, NE 68184

RE: ***Jurisdictional Determination***
Community Hospital of Anderson and Madison County (Prov. No. 15-0113)
FYE 12/31/2009
Case No. 19-2191

Dear Ms. Griffin and Mr. Lamprecht,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On March 9, 2016, the Provider submitted a request for reopening "to recalculate the SSI percentage based on the Hospital's fiscal year rather than the federal fiscal year." Shortly thereafter, on March 18, 2016, the Medicare Contractor acknowledged receipt of the reopening request to recalculate the SSI percentage and issued the Notice of Reopening[1] in which it advised that the cost report was being reopened to "recalculate the hospital's disproportionate share adjustment, if necessary."[2]

The Notice of Amount of Corrected Reimbursement (RNPR)[3] was issued on March 7, 2019.[4] Audit Adjustment No. 5 was made "[t]o adjust the cost report to include the hospital's realignment SSI percentage as calculated by CMS." Similarly, Audit Adjustment No. 6 was made "[t]o adjust the hospital DSH payment percentage based on the hospital's realignment SSI percentage as calculated by CMS."

The individual appeal from the RNPR was filed by the Community Hospital of Anderson and Madison County ("Provider") on July 8, 2019,[5] to which the Board assigned Case No. 19-2191. The RNPR appeal included three (3) issues:

---

[1] Medicare Contractor's Notice of Reopening.
[2] *Id.*
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] Medicare Contractor's Notice of Correction of Program Reimbursement.
[5] Provider's Request for Individual Appeal, at 1.

DSH SSI Ratio Dual Eligible Days
DSH Part C Days
DSH SSI Data Match[6]

The Provider referenced audit adjustments #5 and #6 for all three issues appealed from the RNPR. Adjustment #5 was issued "to adjust the cost report to include the hospital's realignment SSI percentage as calculated by CMS," and adjustment #6 was issued "to adjust the hospital DSH payment percentage based on the hospital's realignment SSI percentage as calculated by CMS."[7]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), 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 (or $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 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)[8] 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.

[6] *Id.*, at 3.
[7] Audit Adjustment Report, at Issue Description.
[8] *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).

> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As set forth below, the Board finds that it does not have jurisdiction over the three issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[9] 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
>
> (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

[9] 42 C.F.R. § 405.1889(b)(1).

> (B) Are furnished to patients entitled to Medicare Part A (including Medicare Advantage (Part C)).[10]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[11] 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***."[12]

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."[13]

[10] (Emphasis added.)
[11] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[12] (Emphasis added.)
[13] (Emphasis added.)

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).[14] 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 DSH Dual Eligible Days, DSH Part C Days, and DSH Data Match issues in the individual appeal.[15] 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.[16]

In conclusion, the Board ***dismisses*** the three issues appealed from the RNPR in Case No. 19-2191 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 19-2191 and removes it from the Board's docket.

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

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

FOR THE BOARD:

8/2/2022

X Clayton J. Nix

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

[14] The only manner in which the Board has determined that it has jurisdiction over these DSH issues *in the context of a revised NPR* is as follows: ***if the data match process is rerun*** *and* generates a new and different SSI percentage, then the Board must necessarily assume that *there was a change in the underlying month-by-month data* and that the Part C days and no-pay Part A days included in that month-by-month data also were changed. Under the realignment process, there is no change in the underlying month-by-month data since the data matching process is not rerun.
[15] The Provider could have appealed these issues from its original NPR, but apparently forewent this opportunity.
[16] *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).

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Bill Tisdale
Novitas Solutions, Inc. (J-H)
707 Grant Street, Suite 400
Pittsburgh, PA 15219

RE: ***Jurisdictional Determination***
Baptist Medical Center (Prov. No. 45-0058)
FYE 08/31/1998
Case No. 14-4206

Dear Messrs. Ravindran and Tisdale,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

The Medicare Contractor issued the Notice of Reopening on August 2, 2013,[1] in which it advised that the cost report was being reopened "[t]o adjust the Provider's SSI% to agree with the SSI% recalculated by CMS using MedPar data for the Provider's cost reporting period ending 08/31/98."[2] Subsequently, the Notice of Amount of Corrected Reimbursement ("RNPR")[3] was issued on March 12, 2014.[4]

Baptist Health System ("Baptist" or "Provider") filed its individual appeal from the RNPR on September 8, 2014,[5] to which the Board assigned Case No. 14-4206. The RNPR appeal included four (4) issues:

DSH SSI Percentage (Provider Specific)
DSH SSI (Systemic Errors)
DSH Payment – SSI Fraction/Medicare Managed Care Part C Days
DSH Payment – SSI Fraction/Dual Eligible Days (Exhausted Part A Benefit Days, Medicare Secondary Payor Days, and No-Pay Part A Days)[6]

[1] MAC's Notice of Reopening Cost Report.
[2] *Id.*
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] MAC's Notice of Program Reimbursement Reopening Settlement #4.
[5] Provider's Request for Individual Appeal, at Model Form A.
[6] *Id.*, at Issue Statement.

The Provider referenced audit adjustment #3 for all four issues appealed from the RNPR. Adjustment #3 was issued, in pertinent part, to adjust the SSI% and the Disproportionate Share Amount based on the latest CMS letter of SSI% Realignment.[7]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), 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 (or $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 RNPR at 42 C.F.R. § 405.1885 (2014), 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 (2014)[8] 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.

[7] Audit Adjustment Report.
[8] *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).

As described below, the Board finds that it does not have jurisdiction over the four issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[9] 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
>
> (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)).[10]

[9] 42 C.F.R. § 405.1889(b)(1).
[10] (Emphasis added.)

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[11] 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***."[12]

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."[13]

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

[11] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[12] (Emphasis added.)
[13] (Emphasis added.)

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 DSH SSI Percentage (Provider Specific), DSH SSI (Systemic Errors), DSH Payment – SSI Fraction/Medicare Managed Care Part C Days, and the DSH Payment – SSI Fraction/Dual Eligible Days issues in the individual appeal. 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.[14]

In conclusion, the Board ***dismisses*** the four issues appealed from the RNPR in Case No. 14-4206 as the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 15-0444 and removes it from the Board's docket.

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

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

FOR THE BOARD:

8/2/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

[14] *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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Decision***
College Station Medical Center (Prov. No. 45-0299)
FYE 10/31/2013
Case No. 16-2494

Dear Mr. Summar,

The Provider Reimbursement Review Board ("Board") has reviewed the record in the above referenced appeal and finds that the sole remaining issue – IME/GME Adjustment – has been abandoned and is hereby dismissed from the appeal. The decision of the Board is set forth below.

Pertinent Facts:

The Board received two separate Individual Appeal Requests from College Station Medical Center ("Provider") September 19, 2016, each appealing its Notice of Program Reimbursement ("NPR") dated March 23, 2016. The first request contained one issue:

1. IME and GME Adjustment – multiple worksheets

The second request contained two additional issues:

2. DSI – SSI – Provider Specific
3. DSH – Medicaid Eligible Days

On June 1, 2017, the Provider filed with the Board its Preliminary Position Paper ("PPP") and the PPP briefed all three issues. The Provider withdrew Issue 3 on February 22, 2022 and Issue 2 on March 20, 2022. As a result, the only remaining issue in this case is Issue 1: IME/GME Adjustment.

On April 6, 2022, the Provider submitted its Final Position Paper ("FPP"). However, the FPP only briefed the DSH – SSI – Provider Specific Issue (Issue 2) which it had previously withdrawn on March 22, 2022.

On May 26, 2022, the Medicare Contractor filed a Jurisdictional Challenge arguing that Issue 1 (IME/GME Adjustment), the only remaining issue, has been abandoned since it was not briefed in the Provider's FPP. Accordingly, the Medicare Contractor requests the Board dismiss the appeal.

Per Board Rule 44.4.3, the Provider had 30 days to file a response. However, the Provider failed to reply. This same Rule explains that "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

Board Decision:

Board Rule 25.3 (Nov. 2021) states that position papers[1] must be complete, and that "[i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

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

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

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

Failure to comply with the Board's briefing requirements for a Final Position Paper can be found at 42 C.F.R. § 405.1868:

---

[1] Board Rule 27.2 establishes that the minimum requirements for Final Position Papers are the same as those outlined for Preliminary Position Papers in Rule 25.
[2] (Bold emphasis added.)

> (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.

Finally, Board Rule 25.3 (Nov. 2021) (as applicable via Board Rule 27.2) states that "[i] f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

The Board finds that the sole remaining issue – IME/GME Adjustments – was not briefed in the Provider's FPP. Pursuant to Board Rule 25.3, the Board deems this unbriefed issue abandoned and effectively withdrawn. Accordingly, the Board hereby dismisses the final issue from the appeal.

Conclusion:

The Board dismisses Issue 1, the IME/GME Adjustment issue, in its entirety from this appeal. Since no issues remain in the appeal, Case No. 16-2494 will be closed and removed from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/2/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kimberly Jones
HCA Healthcare, Inc.
2000 Health Park Dr., 2-North
Brentwood, TN 37027

Dana Johnson
National Gov. Servs., Inc.
P.O. Box 6474 Mailpoint INA101-AF-42
Indianapolis, IN 46206-6474

RE: ***Jurisdictional Determination***
Henrico Doctors' Hospital (Prov. No. 49-0118)
FYE 3/31/2013
Case No. 21-0187

Dear Ms. Jones and Ms. Johnson,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On April 6, 2020, the Medicare Contractor issued the Notice of Reopening due to the Provider's request for realignment:

> We received a request for realignment January 24, 2020. Medicare regulation 412.106(b)(3) provides that cost reports may be revised by the Contractor if a hospital has requested that CMS use its cost reporting period instead of the federal fiscal year for the calculation of the hospital's disproportionate share (DSH) SSI ratio. In accordance with this regulation, we are hereby revising your cost report for the following issue:
>
> 1. Provider requested SSI % recalculation based on the provider's FYE. To ensure proper reporting of the SSI ratio and the Medicare DSH percentage on the cost report based on CMS' recalculation.
>
> 2. To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
>
> 3. To address any cost report software updates and edits, mathematical and flow items and carry forward amounts, as necessary.

> You will be advised of the effect on program reimbursement of this reopening by means of a revised Notice of Program Reimbursement, which we expect will be issued within 180 days of receipt of final documentation.[1]

On May 11, 2020, the Medicare Contractor issued the Notice of Amount of Corrected Reimbursement (RNPR)[2] in which it advised that the cost report had been reopened due to the Provider's request for realignment of the SSI percentage from the federal fiscal year ("FFY") to the Provider's fiscal year and that the RNPR was being issued for that purpose:

> Medicare regulations allow providers to request that the Centers for Medicare & Medicaid Services CMS) ***use the provider's cost reporting period instead of the Federal fiscal year*** *in calculating the* Medicare Part A/Supplemental Security Income (*SSI) percentage* component of the disproportionate patient percentage in the Medicare Disproportionate Share Hospital (DSH) payment.
>
> This request is known as a Medicare Part A/SSI Percentage Realignment Request. The resulting percentage becomes the provider's official Medicare Part A/SSI percentage for that period. See 42 CFR 412.106(b)(3). This letter is to notify you that Palmetto GBA, the Medicare Administrative Contractor (MAC), *received* ***a Medicare Part A/SSI Percentage Realignment Request*** *for the above provider and fiscal year end* on January 24, 2020. The request has been processed by CMS resulting in a Medicare Part A/SSI percentage of 5.33%. Use of the realigned Medicare Part A/SSI percentage in the Medicare DSH calculation resulted in the following:
>
> Net Amount due the Provider: $162,480[3]

The individual appeal from the RNPR was filed by Henrico Doctors' Hospital ("Provider") on November 7, 2020,[4] to which the Board assigned Case No. 21-0187. The RNPR appeal included one (1) issue:

> DSH – Part A Noncovered Days[5]

---

[1] Medicare Contractor's Notice of Cost Report Realignment.
[2] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[3] Provider's Request for Individual Appeal, at 2 (emphasis added).
[4] *Id.,* at 1.
[5] *Id.*, at 3.

The issue statement in the appeal request describes this issue as follows:

> The Provider disagrees with CMS' rule regarding the Medicaid fraction of the DSH calculation excluding from the numerator days attributable to patients who have been identified as eligible for Medicaid and enrolled under Medicare part A, but for which no Medicare Part A payment was made. The DSH regulation prohibits the inclusion of dual eligible days in the numerator of the Medicaid fraction and requires the inclusion of all Medicare Part A non-covered days in the Medicare/SSI fraction. See 42 C.F.R. §412.106(b)(2); 69 Fed. Reg. 48916, 49098-99 (Aug. 11, 2004). The Provider disagrees for the determination of both operating and capital DSH with the inclusion of Part A non-covered days in the Medicare/SSI fraction and the exclusion from the numerator of the Medicaid fraction of Medicaid eligible portion of those days including, but not limited to, the following categories of dual-eligible days:
>
> • Medicaid paid days • Days not paid by Medicare under Medicare Secondary Payer • Days after exhaustion of Medicare Part A benefits for inpatient hospital services • Other Medicare Part A non-covered days.

The Provider referenced audit adjustments #1 and #2 for the issue appealed from the RNPR. Adjustment #1 was issued "[t]o adjust the SSI % to CMS's determination," and adjustment #2 was issued "[t]o adjust DSH Payment Factors based on revised SSI%."[6]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840, a provider has a right to a hearing before the Board with respect to 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 (or $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 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

[6] Audit Adjustment Report, at Issue Description.

> contractor (with respect to contractor determinations), or by the reviewing entity that made the decision. . . .

Additionally, 42 C.F.R. § 405.1889 (2018)[7] 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.

As set forth below, the Board finds that it does not have jurisdiction over the issue in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[8] 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 -

---

[7] *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).
[8] 42 C.F.R. § 405.1889(b)(1).

> (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)).[9]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[10] 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***."[11]

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

[9] (Emphasis added.)
[10] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[11] (Emphasis added.)

> 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."[12]

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).[13] 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 DSH – Part A Noncovered Days issue in the individual appeal (i.e., its challenge to the validity of the Secretary's policy to include no-pay/exhausted Part A days in the SSI percentage when performing the data matching process for the SSI percentage).[14] 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.[15]

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[12] (Emphasis added.)

[13] The only manner in which the Board has determined that it has jurisdiction over the DSH – Part A Noncovered Days issue *in the context of a revised NPR* is as follows: ***if the data match process is rerun*** *and* generates a new and different SSI percentage, then the Board must necessarily assume that *there was a change in the underlying month-by-month data* and that the no-pay Part A days included in that month-by-month data also were changed. Under the realignment process, there is no change in the underlying month-by-month data since the data matching process is not rerun.

[14] The Provider could have appealed this issue from its original NPR, but apparently forewent this opportunity.

[15] *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).

In conclusion, the Board ***dismisses*** the issue appealed from the RNPR in Case No. 21-0187 as the Provider does not have the right to appeal the RNPR at issue for this issue. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 21-0187 and removes it from the Board's docket.

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

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

FOR THE BOARD:

8/2/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ronald Connelly
Powers, Pyles, Sutter & Verville, PC
1501 M St., NW, 7th Fl.
Washington, DC 20005

RE: ***EJR Determination***
22-0644G Powers Pyles CY 2020 Miscalc. of DGME FTE Cap & Res. Weighting Factors Grp
21-1349GC Yale-New Haven CY 2019 Incorrect DGME Cap & Weighting for Residents Beyond IRP CIRP Group

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' request for expedited judicial review ("EJR") in the above-referenced group appeal, which was filed in Case No. 21-1349GC on June 3, 2022 and in Case No. 22-0644G on June 6, 2022.[1] On June 21, 2022 the Board issued a scheduling order giving the Medicare Administrative Contractor until July 18, 2022 to provide comments on jursiciton and/or substantive claim challenges and until August 17th, for the Provider to respond. As jurisdiction is a prerequisite to consideration of an EJR request,[2] the Scheduling Order necessarily affected the 30-day period for the Board's determination of authority required to decide the EJR request. As of July 5th, briefing was complete, and the Board has finalized its jurisdictional review. The Board's decision on jurisdiction and EJR is set forth below.

Issue in Dispute

The Providers' group issue statement describes the 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:

[1] The EJR request was a consolidated request for 5 cases. The remaining cases are addressed under separate cover.
[2] 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 request "[a]ll of the information and documents found necessary by the Board for issuing a[n EJR] decision," including documentation and information related to challenges relating to jurisdiction. *See* 42 C.F.R. § 405.1842(e)(2)(ii) (a decision issued per subsection (f) must include a decision on both jurisdiction and the EJR request).

> 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 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]

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:

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[3] Group Issue Statement for Case No. 22-0644G. The Group Issue Statement for Case No. 21-1349GC is the same except for the end of the last sentence, which states, in pertinent part, as follows: ". . . cost reporting periods ending on or before December 31, 1996, and residents beyond the IRP are weighted at no more than 0.5."
[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 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."

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

[11] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).
[12] 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").[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 § 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:

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[13] 66 Fed. Reg. 39826 (Aug. 1, 2001).
[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."

> 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 are requesting 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 FTE residents 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 it FTE cap. They also trained fellows and other residents who were beyond their initial residency period ("IRP").[20]

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[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).
[19] Providers' Consolidated Petition for Expedited Judicial Review at 1 (June 3 and 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.

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)(iii), 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 two group appeals, 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) (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.

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[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.
[26] Ruling on FSS' Extension Request Relating to Case Nos. 22-0105G, *et al.,* at 9 (June 21, 2022).

A. Jurisdiction

At the outset, the Board notes that Board Rule 20 specifies the following regarding groups fully populated in OH CDMS such as the instant groups:

> *Prior to certifying that the group is fully formed or the date on which a group is fully formed*, the group representative should review each participating provider's supporting jurisdictional documentation to ensure it is complete and, if not, file any additional documentation in OH CDMS. If all of the participants in a fully-formed group are populated under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, *the group representative* ***must file*** *a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation* (i.e., all participants in the group are shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[27]

Here, the Group Representative failed to file the certification required in Board Rule 20 as a separate and independent filing within 60 days of full formation of these groups. Notwithstanding, the Board recognizes that the request for EJR includes a detailed account of the Board's jurisdiction over each participant. *As a* ***one-time*** *courtesy*, the Board is treating the EJR request as satisfying the Board Rule 20 certification requirement. ***The Board directs the Group Representative to review and come into compliance with Board Rule 20 as the Board may take remedial action if the Group Representative fails to come into compliance.***[28]

The Providers in these group cases are appealing from cost reporting periods beginning on or after January 1, 2016. The Board notes that the November 13, 2015 OPPS Final Rule eliminated the ***jurisdictional*** requirement in the then-existing 42 C.F.R. §§ 405.1835(a)(1) and 405.1840(b)(3) 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*.[29]

Each of the providers participating in these groups timely file an appeal as direct adds to the relevant group, and the Board has not identified any jurisdictional impediments to their participation in the groups. The Providers' documentation shows that the estimated amount in

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[27] (Emphasis added.)
[28] The Board requires this certification of group representatives in order to notify both the Board and the opposing party that the group is ready for jurisdictional review. To this end, the group representative certifies that: (1) he/she is not required to file a hard copy Schedule of Providers since it has confirmed that ***all*** participants in the group are fully populated in OH CDMS as participants; and (2) he/she has confirmed that ***all*** relevant supporting jurisdictional documentation is available under this case in OH CDMS for those participants (*i.e.*, no documentation is needed or missing). *Following that certification*, the Medicare Contractor then has 60 days to review the jurisdictional documents and file, as relevant, any jurisdictional challenges. Thus, it is the certification that the group representative is required to file per Board Rule 20 that triggers jurisdictional review (as opposed to notice of full formation of the group).
[29] 80 Fed. Reg. 70298 (Nov. 13, 2015).

controversy in each of the group appeals exceeds $50,000, as required for a group appeal.[30] Finally, the Board has determined that there is only one issue in each of these appeals concerning the Provider challenge to the validity of 42 C.F.R. § 413.79(c)(2)(iii) for the alleged disparate treatment between residents in their initial training period and fellows. Based on the above, the Board finds that it has jurisdiction over the above-captioned group appeals and underlying participants.

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

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.[31] 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.[32]

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"[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 these group cases, the Medicare Contractor did not file a Substantive Claim Challenge.

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[30] *See* 42 C.F.R. § 405.1837.
[31] 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"). The Providers in Case No. 21-1349GC appealed from cost reporting periods with fiscal year end of September 30, 2019, and the Providers in Case No. 22-0644G appealed from cost reporting periods with fiscal year end of June 30, 2020.
[32] 42 C.F.R. § 413.24(j)(2) sets forth the procedures for self-disallowing a specific item on the cost report.
[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).

As such, since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made,[35] 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. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered. Accordingly, the Board will proceed to rule on the EJR request pursuant to 42 C.F.R. § 405.1873(d).

C. *Board's Analysis of the Appealed Issue*

The Providers assert that the regulation at 42 C.F.R. § 413.79(c)(2)(iii) penalizes hospitals which exceed their FTE caps because of the perceived disparate treatment between residents in their initial training period and fellows. The Providers assert that § 413.79(c)(2)(iii) states the following equation for calculating the weighted cap (*i.e.* "Allowable FTE Count") for a particular fiscal year ("FY") and that this formula results in the perceived disparate treatment between IRP residents and fellows.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [36]

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.[37] 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.[38] 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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[35] 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."

[36] EJR Request at 10.

[37] *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.)).

[38] 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].[39]

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.[40] 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."[41] 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[42] (*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.[43]

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[39] (Emphasis added.)

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

[41] *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.)).

[42] 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.

[43] 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

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 Findings Regarding the EJR Requests

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, and ***it directs the Group Representative to review and come into compliance with the following requirement in Board Rule 20***:

> If all of the participants in a fully-formed group are populated under the Issues/Providers Tab in OH CDMS, then ***within (60) sixty days of the full formation of the group***, *the group representative* ***must file*** *a statement certifying that the group is fully populated in OH CDMS with the relevant supporting jurisdictional documentation* (*i.e.*, all participants in the group are

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.

shown under the Issues/Providers Tab for the group in OH CDMS with the relevant supporting jurisdictional documentation).[44]

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

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

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

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

The 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:

8/2/2022

X Clayton J. Nix

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

Encl: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Danelle Decker, National Government Services, Inc.
Wilson Leong, FSS

[44] (Emphasis added). *See* Decision, Subsection A and *supra note* 28 (discussing Board Rule 20).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Denial of EJR Requests & Scheduling Order***
14-2873GC Ardent Health Servs 2010 Post 1498-R DSH Medicaid Fraction Dual Elig. Days CIRP
14-2874GC Ardent Health Servs 2010 Post 1498-R DSH SSI Fraction Dual Elig. Days CIRP
14-3717GC Ardent Health Servs 2011 Post 1498-R DSH Medicaid Fraction Dual Elig. Days CIRP
14-3718GC Ardent Health Servs 2011 Post 1498-R DSH SSI Fraction Dual Elig. 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 29, 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 20, 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.

[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).

Board's Scheduling Order Issued June 29, 2022

On June 29, 2022, the Board issued a Scheduling Order, requiring a response from QRS within 21 days (*i.e.*, by July 20, 2022). 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 20, 2022 Response

QRS responded on July 20th, 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]

Accordingly, QRS requested an additional 14 days in which to submit the Providers' updated EJR requests.

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[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).

Discussion and Board Decision

The Board notes that there are 4 CIRP group appeals to which the Board requested additional briefing, and to which the Provider responded. 2 of the appeals are specific to the Medicare fraction and 2 are related appeals specific to the Medicaid fraction. Ardent 2010 and 2011 each have a set of 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.

Medicare Fraction Only
14-2874GC Ardent Health Servs 2010 Post 1498-R DSH SSI Fraction Dual Eligible Days CIRP
14-3718GC Ardent Health Services 2011 Post 1498-R DSH SSI Fraction Dual Eligible Days CIRP

Medicaid Fraction Only
14-2873GC Ardent Health Servs 2010 Post 1498-R DSH Medicaid Fraction Dual Elig. Days CIRP
14-3717GC Ardent Health Servs 2011 Post 1498-R DSH Medicaid Fraction Dual Elig. Days CIRP

QRS' July 20, 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 A days excluded from the Medicare fraction and, to the extent those days involve dually eligible patients, included in the numerator of the Medicaid fraction. 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. 14-2873GC (Ardent Health Services 2010 Post 1498-R DSH Medicaid Fraction Dual Eligible Days CIRP Group) and 14-3717GC (Ardent Health Services 2011 Post 1498-R DSH Medicaid Fraction Dual Eligible Days CIRP Group). 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 2 CIRP group appeals under Case Nos. 14-2874GC and 14-3718GC, the Board is holding these cases open, ***until Thursday, September 1, 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 Thursday, September 1, 2022***, QRS must file, in each remaining 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***:

1. Include a copy of the original group issue statement used to establish the group and explain how the original 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*** 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.

[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 issuing this RFI, the Board is ***not*** granting QRS leave to submit any additional jurisdictional documentation required to be part of the final SoP.

> (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 already included as 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 Friday, September 30, 2022***.

Following the passing of the deadline without a timely submission, or a Board ruling on a timely-filed bifurcation request, the Board will close these 2 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.

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, the 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). Similarly, the failure of the Medicare Contractors to file a response will

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[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.

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:

8/3/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Denial of EJR Requests & Scheduling Order***
17-0808GC QRS BSWH 2014 DSH Medicaid Fraction Dual Elig. Days (Late Issuance of NPR) CIRP
17-0811GC QRS BSWH 2014 DSH SSI Fraction Dual Eligible Days (Late Issuance of NPR) CIRP
18-1280GC QRS BSWH 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group
18-1281GC QRS BSWH 2015 DSH SSI Fraction Dual Eligible Days CIRP Group

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 29, 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 20, 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.

[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).

Board's Scheduling Order Issued June 29, 2022

On June 29, 2022, the Board issued a Scheduling Order, requiring a response from QRS within 21 days (*i.e*., by July 20, 2022). 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 20, 2022 Response

QRS responded on July 20th, 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]

Accordingly, QRS requested an additional 14 days in which to submit the Providers' updated EJR requests.

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[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).

Discussion and Board Decision

The Board notes that there are 4 CIRP group appeals to which the Board requested additional briefing, and to which the Provider responded. 2 of the appeals are specific to the Medicare fraction and 2 are related appeals specific to the Medicaid fraction. BSWH 2014 and 2015 each have a set of 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.

Medicare Fraction Only
17-0811GC QRS BSWH 2014 DSH SSI Fraction Dual Eligible Days (Late Issuance of NPR) CIRP
18-1281GC QRS BSWH 2015 DSH SSI Fraction Dual Eligible Days CIRP Group

Medicaid Fraction Only
17-0808GC QRS BSWH 2014 DSH Medicaid Fraction Dual Eligible Days (Late Issuance of NPR) CIRP
18-1280GC QRS BSWH 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group

QRS' July 20, 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 A days excluded from the Medicare fraction and, to the extent those days involve dually eligible patients, included in the numerator of the Medicaid fraction. 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.

17-0808GC (QRS BSWH 2014 DSH Medicaid Fraction Dual Eligible Days (Late Issuance of NPR) CIRP Group) and 18-1280GC (QRS BSWH 2015 DSH Medicaid Fraction Dual Eligible Days CIRP Group). 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 2 CIRP group appeals under Case Nos. 17-0811GC and 18-1281GC, the Board is holding these cases open, ***until Thursday, September 1, 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 Thursday, September 1, 2022***, QRS must file, in each remaining 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***:

1. Include a copy of the original group issue statement used to establish the group and explain how the original 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*** 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 not allowed to aggregate claims involving different issues**.

[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 issuing this RFI, the Board is ***not*** granting QRS leave to submit any additional jurisdictional documentation required to be part of the final SoP.

> (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 already included as 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 Friday, September 30, 2022***.

Following the passing of the deadline without a timely submission, or a Board ruling on a timely-filed bifurcation request, the Board will close these 2 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.

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, the 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). Similarly, the 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.

---

[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.

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:

8/3/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Denial of EJR Requests & Scheduling Order***
19-2458GC BS&W Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group
19-2460GC BS&W Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group

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 29, 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 20, 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 29, 2022

On June 29, 2022, the Board issued a Scheduling Order, requiring a response from QRS within 21 days (*i.e*., by July 20, 2022). 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

[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).

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 20, 2022 Response

QRS responded on July 20th, 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]

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 2 CIRP group appeals to which the Board requested additional briefing, and to which the Provider responded. BSWH 2016 have a set of 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.

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[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).

Medicare Fraction Only
19-2458GC BS&W Health CY 2016 DSH SSI Fraction Dual Eligible Days CIRP Group

Medicaid Fraction Only
19-2460GC BS&W Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group

QRS' July 20, 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 A days excluded from the Medicare fraction and, to the extent those days involve dually eligible patients, included in the numerator of the Medicaid fraction. 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 CIRP group appeal 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. 19-2460GC (BS&W Health CY 2016 DSH Medicaid Fraction Dual Eligible Days CIRP Group). 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 CIRP group appeal under Case Nos. 19-2458GC, the Board is holding this case open, ***until Thursday, September 1, 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 Thursday, September 1, 2022***, QRS must file, in the remaining 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***:

1. Include a copy of the original group issue statement used to establish the group and explain how the original 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*** 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 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).

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 already included as 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 Friday, September 30, 2022***.

Following the passing of the deadline without a timely submission, or a Board ruling on a timely-filed bifurcation request, the Board will close the remaining case since QRS abandoned

[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 issuing this RFI, the Board is ***not*** granting QRS leave to submit any additional jurisdictional documentation required to be part of the final SoP.
[5] *See supra* note 4.

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 ***and*** has established a new CIRP group for that issue.

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, the 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). Similarly, the 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:

8/3/2022

X Clayton J. Nix

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

cc: Bill Tisdale, Novitas Solutions, Inc.
Wilson Leong, FSS

[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.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

L. Rene Shannon
Atrium Health
4400 Golf Acres Dr., Bldg J, Ste. A
Charlotte, NC 28208

RE: ***Jurisdictional Decision***
Navicent Health Medical Center of Central Georgia (Prov. No. 11-0107)
FYE 09/30/2010
Case No. 22-0936

Dear Ms. Shannon:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Navicent Health Medical Center of Central Georgia's ("Provider") Individual Appeal Request on appeal on March 10, 2022 appealing from a Notice of Program Reimbursement ("NPR") dated November 20, 2018 (and revised NPR dated September 27, 2021) for fiscal year ending September 30, 2011. The decision of the Board is set forth below.

Procedural history:

On April 22, 2021 the MAC issued a notice to reopen the Provider's cost report. The MAC listed the reasons for reopening:

1. Provider requested a review of Medicare Discharges, and comprising subsequent calculation components, in qualifying for the Additional Payment for High Purchase of ESRD Beneficiary Discharges.
2. Provider requested a review of the hospital settlement data using updated amounts.
3. To incorporate settlement amounts from the previous cost report settlement to ensure proper determination of payments, as necessary.
4. To address any cost report software updates and edits, mathematical and flow items and carry forward amounts, as necessary.[1]

The MAC then issued a RNPR on September 8, 2021. The adjustments in the RNPR relate to the ESRD add on issue and associated adjustments.

[1] Notice of Cost Report Reopening (April 22, 2021).

On March 10, 2022 the Board received Provider's Individual Appeal Request appealing its September 27, 2021 RNPR for fiscal year ending September 30, 2011. The initial appeal contained the following single issue:

1. IPPS Standardized Amount

The audit adjustment cited as supporting this issue is Audit Adjustment No. 9 which adjusted "DRG Amounts Other Than Outlier Payments" by adding $1,798.

The Board has reviewed jurisdiction over the sole issue in this appeal on its own motion, and the decision is set forth below.

Board Decision:

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

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2021), 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 (2021)[2] 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.

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

> (b)(1) Only those matters that are specifically revised in a revised determination or decision are within the scope of any appeal of the revised determination or decision.
>
> (2) Any matter that is not specifically revised (including any matter that was reopened but not revised) may not be considered in any appeal of the revised determination or decision.

As outlined above, when a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[3] In this case, the adjustment of Medicare IPPS payments to resolve a Flawed Standardized Amount issue was not specifically revised. The cost report was reopened in order for the MAC to review discharges in qualifying for additional Payment for High Purchase of ESRD Beneficiary Discharges, which is not the same as the IPPS standardized amount issue.

Moreover, while the total amount of DRGs were adjusted as part of this reopening, it is unclear why they were adjusted (*e.g.*, adjusted based on mathematical corrections per the 4th reopening reason, or a more recent Provider Statistical & Reimbursement Report ("PS&R")[4]). The Board need not resolve that question because the total amount of the DRG-related adjustment was ***less than $2,000*** and, as such, the amount in controversy could only be a fraction of that $2,000. In other words, the Provider's appeal rights, if any, under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a) would be limited to the adjustment to add $1,798 in DRG payments since appeal rights are limited "those matters that are specifically revised in a revised determination." The issue related to that $1,798 would only result in 1 percent addition to the $1,798 per the Provider's method of calculating the amount in controversy. This would be clearly less than the minimum $10,000 needed to establish an individual appeal as specified in § 405.1835(a).

The Board finds that it lacks jurisdiction over the standardized amount issue as it does not fit in the scope of issues that can be appealed from the RNPR at issue nor would the amount adjusted be sufficient to meet the minimum amount in controversy required to establish an individual appeal.[5] 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.[6]

---

[3] 42 C.F.R. § 405.1889(b)(1).
[4] If the addition of the $1,798 was due to a more recent PS&R, then it is likely that the $1,798 represents a single hospital stay (*i.e.*, a single DRG payment).
[5] The Provider could have appealed this issue from its original NPR or the relevant IPPS final rule, but apparently forewent this opportunity.
[6] *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).

Conclusion

The Board hereby dismisses the IPPS Standardized Amount issue. As this is the only issue in the appeal it would then be closed. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members:

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

For the Board:

8/3/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

ia Electronic Delivery

Pamela VanArsdale
National Government Services, Inc.
MP: INA 101-AF42
P.O. Box 6474
Indianapolis, IN 46206-6474

Nicolas Putnam
Manager - Consultant
Strategic Reimbursement Group, LLC
360 West Butterfield Road, Suite 310
Elmhurst, IL 60126

RE: ***Jurisdictional Decision***
SRI FY 2008 Unmatched Medicaid Eligible Days Group
Case No. 14-1571G

Dear Ms. VanArsdale and Mr. Putnam:

The Provider Reimbursement Review Board ("Board") has reviewed the jurisdictional documents in the above referenced optional appeal and finds that it does not have jurisdiction over the Jackson Park Hospital (Provider No. 14-0177) in the above optional group appeal. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Providers filed this optional group appeal on December 6, 2013. The group issue is described as:

> Unmatched Medicaid Eligible Days
>
> The Provider contends that the Medicaid fraction of its Operating Disproportionate Share Hospital, Low Income Payment, and Capital Disproportionate Share Hospital adjustment calculations (collectively "Calculations") has not been calculated in accordance with Medicare regulations and manual provisions as described in 42 CFR 412.106.
>
> The provider requests that patient days pertaining to additional patient stays that were not paid by Medicaid, but related to patients with Medicaid coverage during the stay be included in the Medicaid fraction of the Calculations.[1]

The initial Request for Appeal included two participants:

[1] CN 14-1571G, Group Appeal Request, Tab 2 "Statement of Group Issues" at 1 (Nov. 25, 2013).

1) Henry Mayo Newhall Memorial Hospital (PN 05-0624), FYE 09/30/2008 (**Withdrawn)**, and

2) Watauga Medical Center (PN 34-0051), FYE 09/30/2008 (**Withdrawn)**.

The following participants subsequently requested transfer to this group appeal:

3) Swedish Covenant Hospital (PN 14-0114), FYE 09/30/2008, requested transfer from individual CN 14-0418 to this appeal on July 29, 2014 (**Withdrawn)**,

4) Norwegian American Hospital (PN 14-0206), FYE 09/30/2008, requested transfer from individual CN 14-0378 on June 18, 2014,

5) Saint Joseph Health Center (PN 36-0161), FYE 12/31/2008, requested transfer from individual CN 13-3550 on May 30, 2014 (**Not on Final SOP)**,

6) Mercy Hospital and Medical Center (PN 14-0158), FYE 06/30/2008, requested transfer from individual CN 13-3204 on May 1, 2014,

7) Reading Hospital (PN 39-0044), FYE 06/30/2008, requested transfer from individual CN 13-3498 on April 25, 2014 (**Withdrawn)**,

8) Saint Anthony Hospital (PN 14-0095), FYE 06/30/2008, requested transfer from individual CN 13-3035 on April 28, 2014,

9) Thorek Memorial Hospital (PN 14-0115), FYE 06/30/2008, requested transfer from individual CN 13-3033 on April 28, 2014,

10) Sierra Regional Health Center (PN 03-0043), FYE 06/30/2008, requested transfer from individual CN 13-3494 on April 28, 2014,

11) Saint Joseph Hospital of Orange (PN 05-0069), FYE 06/30/2008, requested transfer from individual CN 13-2699 on March 31, 2014 (**Withdrawn)**, and

12) Jackson Park Hospital (PN 14-0177), FYE 03/30/2008, requested transfer from individual CN 13-3025 on March 24, 2014.

On April 23, 2015, Participant No. 3 (Swedish Covenant Hospital) requested to be withdrawn from this group appeal. On January 19, 2021, Participant Nos. 1 (Henry Mayo Newhall Memorial Hospital), 2 (Watauga Medical Center), 7 (Reading Hospital) and 11 (Saint Joseph Hospital of Orange) withdrew from the group appeal.

The Updated Schedule of Providers and supporting documentation submitted June 17, 2021, contain six Participants. The Medicare Contractor has filed a Jurisdictional Challenge (Dec. 10, 2021) regarding Jackson Park Hospital (Prov. No. 14-0177), FYE 03/31/2008. The Medicare Contractor states this Jurisdictional Challenge supersedes the Jurisdictional Challenge dated July 30, 2015.

Medicare Contractor's Position

The Medicare Contractor contends the specific issue in dispute – Medicaid eligible days in the DSH Medicaid fraction – was not adjusted in the Revised Notice of Program Reimbursement ("RNPR") issued to Jackson Park Hospital. Therefore, no final determination was made for this item in the RNPR. The Medicare Contractor notes that Jackson Park Hospital appealed from its initial NPR in PRRB Case No. 10-0213, but that case was closed on November 4, 2015. The RNPR was issued on February 20, 2013, and the Provider's appeal of the RNPR resulted in PRRB Case No. 13-3025. The DSH Medicaid Eligible Day issue was added to Case No. 13-3025 and transferred to this group appeal.

The Medicare Contractor argues that in both the initial SOP and supporting docs submitted on March 30, 2015, as well as the Updated SOP and supporting docs submitted on June 17, 2021, the Provider incorrectly included the adjustment report from the original NPR rather than the adjustment report from the RNPR dated February 20, 2013. The Medicare Contractor has included the adjustment report for the RNPR as Exhibit C-3 in its Jurisdictional Challenge.

The Medicare Contractor asks the Board to dismiss Jackson Park Hospital (PN 14-0177) from the group appeal, arguing this Provider does not meet jurisdictional requirements. Specifically, the item at issue in the group appeal was not adjusted in the Provider's RNPR. Thus, there was no Medicare Contractor final determination that is the basis of the appeal and this Provider should be dismissed in accordance with 42 C.F.R. § 405.1887(d) and 42 C.F.R. § 405.1889.

Provider's Position

The Provider filed a Response to the MAC's Jurisdictional Challenge on March 28, 2022. The Provider states the MAC did not reference an expected adjustment, and appears to suggest an S-3 Part I Column 5 adjustment is lacking. The Provider claims any such adjustment would be a reconciling entry to tie S-3 Part I to E, Part A as S-3 provides no determination of Medicare DSH payment.

The Provider asserts that adjustments were made to the DSH SSI percentage pursuant to CMS Ruling 1498-R, and the resulting DSH revision "was a direct determination of the treatment of days between Medicaid and Medicare fractions of the Disproportionate Patient Percentage (DPP)." The Provider argues it is this adjustment which is under appeal. The Provider also cites to Ruling 1498-R as rendering prior appeals of the DSH adjustment moot, and providing opportunity for the Revised NPR to now be subject to administrative and judicial review.

The Provider states it identified a practical impediment in the group's Preliminary Position Paper, including a lengthy explanation of efforts made to identify all days, and explanations as to why days were not identifiable as Medicaid eligible. The Provider indicates it did not submit the disputed days listing with the Preliminary Position Paper as it contained PHI. The days listing has since been provided to the Medicare Contractor. The Provider argues that all jurisdictional requirements have been met, and the Board has jurisdiction over Jackson Park Hospital in this group appeal.

Relevant Regulations – Revised NPRs:

The Code of Federal Regulations provides for an opportunity for a reopening and RNPR at 42 C.F.R. § 405.1885 (2008), which provides in relevant part:

> (a) General. (1) A Secretary determination, an intermediary determination, or a decision by a reviewing entity (as described in § 405.1801(a)) 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 intermediary (with respect to intermediary determinations), or by the reviewing entity that made the decision…

Additionally, 42 C.F.R. § 405.1889 (2008)[2] explains the effect of a cost report revision:

> (a) If a revision is made in a Secretary or intermediary 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.

[2] *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).

> (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. § 405.1837(a) states

> (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 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)…

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

> (a) *Right to hearing on final contractor determination*. A provider . . . has a right to a Board hearing, as a single provider appeal, with respect to a final contractor or Secretary determination for the provider's cost reporting period, if -
>
> (1) The provider is dissatisfied with the contractor's final determination of the total amount of reimbursement due the provider, as set forth in the contractor's written notice specified under § 405.1803. **Exception**: If a final contractor determination is reopened under § 405.1885, **any review by the Board must be limited solely to those matters that are specifically revised in the contractor's revised final determination** (§§ 405.1887(d), 405.1889(b), and the "Exception" in § 405.1873(c)(2)(i)).[3]

Board Decision

The Board finds that it does not have jurisdiction over Jackson Park Hospital's appeal of the RNPR dated February 20, 2013 because Medicaid Eligible Days were not specifically revised or adjusted. Here, the Provider's audit adjustment report shows that there was an adjustment to the DSH Medicare/SSI fraction, ***not*** the Medicaid fraction (much less the Medicaid Eligible Days

[3] (Emphasis added.)

included in the numerator of the Medicaid fraction as required for jurisdiction pursuant to 42 C.F.R § 405.1889.

When a final determination is reopened and revised, an appeal from the revised determination is limited in scope to "[o]nly those matters that are specifically revised[.]"[4] Jackson Park Hospital appealed the RNPR dated February 20, 2013 but did not submit the correct audit adjustment report under Tab 1D in the Schedule of Providers and Supporting Documentation (June 17, 2021) – the audit adjustment report submitted is dated July 15, 2009 and clearly was not issued in connection with the February 20, 2013 RNPR. Further, the Provider failed to include in the Schedule of Providers a copy of the Medicare Contractor's Notice of Reopening.[5]

The Medicare Contractor submitted the correct audit adjustment report for this RNPR as Exhibit C-3 with its Jurisdictional Challenge filed on December 10, 2021. The correct audit adjustment report indicates adjustments were only made to the Medicare/SSI fraction of the DSH payment calculation with Audit Adjustment Nos. 5 and 8.[6] There is no evidence that the DSH Medicaid fraction or Medicaid Eligible Days in the numerator of the Medicaid fraction were adjusted in this RNPR.

In conclusion, the Board dismisses Jackson Park Hospital (Provider No. 14-0177, FYE 03/31/2008) from Case No. 14-1571G because, pursuant to 42 C.F.R. § 405.1889(b), the Provider did not have a right to appeal from the RNPR for the issue in this group appeal. 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.[7] The case remains open as there are five remaining Participants in the optional group 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:

8/4/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS

[4] 42 C.F.R. § 405.1889(b)(1).
[5] Board Rules 7.1.2.1, 16.1.2.
[6] The Board recognizes that Audit Adjustment No. 8 references CMS Ruling 1488-R as follows: "[t]o update for Capital DSH in accordance with CMS Ruling 1498-R. However, CMS Ruling 1498-R only concerns the SSI fraction as evidenced by the fact that only the SSI fraction was adjusted in the RNPR at issue.
[7] *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).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ronald Connelly, Esq.
Powers, Pyles, Sutter & Verville, PC
1501 M St., NW, 7th Fl.
Washington, DC 20005

RE: ***EJR Determination***
Powers Pyles CY 2019 Miscalc. of DGME FTE Cap & Resident Weighting Factors Grp
Case No. 22-0125G

Dear Mr. Connelly:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' request for expedited judicial review ("EJR") in the above-referenced group appeal.[1] The Providers' request for EJR was filed on June 6, 2022 in this case. On June 13, 2022, Federal Specialized Services ("FSS") requested an extension of time to respond to the EJR request, which was granted by the Board.[2]

On July 19, 2022, FSS filed a substantive claim challenge for two of the five Providers, namely University of Missouri Health Care and Penn State Health Milton S. Hershey Medical Center, asserting that those two providers did not self-disallow or make a claim on their cost reports in accordance with 42 C.F.R. § 413.24(j). On July 28, 2022, the Medicare Contractor filed a letter further clarifying some of FSS' arguments in the substantive claim challenge. Later that same day, the Providers' filed a response to the substantive claim challenge, asserting the two Providers did self-disallow.[3] In addition, the Providers responded to the Board's EJR Scheduling Order, and filed a second EJR request on the validity of the substantive claim regulations.

The Board has reviewed and considered each of these filings. The decision of the Board is set forth below.

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[1] The EJR request was a consolidated request for a total of five cases. The remaining cases have been addressed under separate cover.

[2] *See* Decision re: Request for Extension – Notice of 30-Day Deadline (June 21, 2022). While the Providers, in their Substantive Claim Challenge Response filed on July 28, 2022, now dispute for the first time the timeliness of FSS' extension request, the Board already made a finding with regard to timeliness of the request in their letter granting the extension of time. *Id.* at 1 n.4. Therefore, this issue will not be re-decided.

[3] In their response, the Providers indicate the MAC's substantive claim challenge letter was untimely because the Board's EJR Scheduling Order directed the MAC to file any substantive claim challenge no later than July 18, 2022, and the challenge was filed on July 19, 2022. The Providers argue that therefore, the filing must be rejected. The Board has considered the Providers argument, and acknowledges that the response was filed on July 19. However, the filing was only 45 minutes late, as it was filed at 12:45AM on July 19. While the Board strongly discourages late filings, the Board will accept the substantive claim challenge under the particular circumstances of this case.

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 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.[4]

Background

The Medicare statute requires the Secretary[5] to reimburse hospitals for the "direct" costs of hosting graduate medical training programs for physician residents (direct graduate medical education or "DGME").[6] These costs include the salaries of teaching physicians and stipends paid to resident physicians.[7]

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

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.[8]

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[9] ("*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")[10] 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:

---

[8] 42 U.S.C. § 1395(h).
[9] "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).
[10] Pub. L. 105–33, § 4623, 111 Stat. 251, 477 (1997).

> [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.[11]

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.[12] 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

[11] 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.
[12] 62 Fed. Reg. 45966, 45967, 46004 (Aug. 29, 1997).

> 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.[13]

Section 413.86(g)(4) remained unchanged until the FY 2002 IPPS final rule published on August 1, 2001 ("FY 2002 IPPS Final Rule").[14] 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

[13] 62 Fed. Reg. at 46005 (emphasis added).
[14] 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.[15]

To codify this change, the Secretary added clause (iii) to 42 C.F.R. § 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).[16] 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.[17]

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.[18]

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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[15] *Id.* at 39894 (emphasis added).
[16] *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."
[17] 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.
[18] 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.[19]

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 and the FTE weighting factors, arguing that it is contrary to statute because it determines the cap after application of weighting factors.[20] 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").[21]

The Providers claim that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute for several reasons. First, the regulation creates a weighted FTE cap. The statute requires a cap determination "before the application of the weighting factors" which is an unweighted cap.[22] 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,[23] 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.[24]

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.[25]

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

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[19] 42 U.S.C. § 1395ww(h)(4)(G)(i).
[20] 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")).
[21] *Id.* at 9.
[22] *Id.* (citing 42 U.S.C. § 1395ww(h)(4)(F)(i)).
[23] WFTE is weighted FTE; UCap is unweighted cap; UFTE is unweighted FTE; Wcap is weighted cap.
[24] EJR Request at 9-10 (citing 42 U.S.C. §1395(h)(4)(F)(i)).
[25] *Id.* at 10-13.

hospital's unweight FTE count for 1996 and by doing so, Congress entitled Providers to claim FTEs up to that cap.[26]

The Providers conclude that the regulation, 42 C.F.R. § 413.79(c)(2)(iii), is contrary to the statute, is arbitrary and capricious and an abuse of discretion.

FSS' Substantive Claim Challenge and Providers' Response

In its substantive claim challenge letter dated July 18, 2022, FSS asserts that the two Providers, University of Missouri Health Care (Provider No. 26-0141) and Penn State Health Milton S. Hershey Medical Center (Provider No. 39-0256), failed to describe how the estimated impact on Medicare reimbursement was computed, as required by 42 C.F.R. § 413.24(j)(2).

In response, the two Providers argue that they both complied with the regulation in that both Providers estimated the reimbursement impact and attached to the cost report an explanation containing a "reasonable methodology," referring to the CMS' Provider Reimbursement Manual (PRM), Pub. 15-2, § 115.2, which states that providers should apply a "reasonable methodology which closely approximates the actual effect of the item." Specifically, both Providers provided the amounts of the estimated impact, and explained that their reimbursement impact was calculated by imposing a weighting factor of 0.5 (and no more) for residents who are beyond the initial residency period and applying the full FTE cap. The Providers asserts that no more than this is required. The methodology must only be "reasonable."

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

[26] *Id.* at 13.

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;[27]
- 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.[28]

In this case, the Providers timely appealed from NPRs or amended NPRs. The claimed amount in controversy in this case exceeds the $50,000 threshold. The Board has not found any jurisdictional impediments to the Providers participation in the group. For these reasons, the Board has determined that it has jurisdiction over this case 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 for Cost Reports Beginning on or After January 1, 2016

1. Regulatory Background

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

> (1) *General Requirement*. In order for a provider to receive or potentially qualify for reimbursement for a specific item for its cost reporting period, the provider's cost report, whether determined on an as submitted, as amended, or as adjusted basis (as prescribed in paragraph (j)(3) of this section), **must include an appropriate claim for the specific item**, by either—
>
> (i) Claiming full reimbursement in the provider's cost report for the specific item in accordance with Medicare policy, if the 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.

[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.

> (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.[29]

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

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

[29] (Bold and underline emphasis added.)

> 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**.[30]

These regulations are applicable to the cost reporting periods of the five participants in this group case, which begin on either July 1, 2018 or January 1, 2019.

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

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject the regulations on the "substantive reimbursement requirement" for an appropriate cost report claim.[31] 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))"[32] 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"[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)

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[30] (Bold and underline emphasis added.)
[31] 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").
[32] (Emphasis added.)
[33] 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.[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 two of the five participants (University of Missouri Health Care (Provider No. 26-0141) and Penn State Health Milton S. Hershey Medical Center (Provider No. 39-0256)).

As such, since the MAC has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made for two of the five Providers, 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 for the two Providers. The Board notes that both parties have submitted their arguments and evidence, and 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;

[34] *See* 42 C.F.R. § 405.1873(a),

> (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.

a) Findings on University of Missouri Health Care's Compliance with § 413.24(j)

The documentation submitted to the MAC for this Provider includes Worksheet E-4, and a paragraph description of the issue. The MAC asserts in the substantive claim challenge that the Provider identified the estimated impact on Medicare reimbursement but failed to describe how the estimated impact was computed. In response, the Provider asserts that University of Missouri Health Care estimated the reimbursement impact at $847,915 and explained that "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 many residents who are beyond the initial residency period and prevents the Provider from claiming its full FTE cap," and attached the submission as Exhibit P-2. The Provider asserts that it explained that its reimbursement impact was calculated by imposing a weighting factor of 0.5 (and no more) for residents who are beyond the initial residency period and applying the full FTE cap. The Provider asserts that nothing more is required, as the methodology must only be "reasonable," referring to the language in PRM, Pub. 15-2, § 115.2, quoted above.

The Board finds that the paragraph description of the issue, in which the Provider describes the issue and the estimated impact, in conjunction with Worksheet E-4, which demonstrates the calculation of the DGME Penalty, is sufficient to meet the requirements of § 413.24(j)(2) for self-disallowing a specific item. First, the Provider included an estimated reimbursement amount for the specific item which ties to the cost report (as required in § 413.24(j)(2)(i)) and the paragraph description clearly "explain[s] why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)" (as required in § 413.24(j)(2)(ii)). Finally, the Provider explained that in their calculation they applied the full FTE cap rather than the weighted cap and all the data points for that calculation are located on Worksheet E-4. Based on these unique circumstances, the Board also finds that the Provider has provided a sufficient "descri[ption of] how the provider calculated the estimated reimbursement amount" for the specific self-disallowed item as required in 42 C.F.R. § 413.24(j)(2)(ii). Accordingly, the Board finds that the Provider met the requirement of § 413.24(j)(2) for self-disallowing the DGME issue in this appeal.

b) Findings on Penn State Health Milton S. Hershey Medical Center's Compliance with § 413.24(j)

The documentation submitted to the MAC for this Provider includes Worksheet E-4, and a paragraph description of the issue. The MAC asserts in the substantive claim challenge that the

Provider identified the estimated impact on Medicare reimbursement but failed to describe how the estimated impact was computed. In response, the Provider asserts that Penn State Milton S. Hershey Medical Center estimated the reimbursement impact at $1,407,673 and explained that "CMS's implementation of the cap and weighting factors is contrary to the statute because it imposes on the Provider a weighting factor of less than 0.5 for many residents who are beyond the initial residency period and prevents the Provider from claiming its full FTE cap," and attached the submission as Exhibit P-3. The Provider asserts that it explained that its reimbursement impact was calculated by imposing a weighting factor of 0.5 (and no more) for residents who are beyond the initial residency period and applying the full FTE cap. The Provider asserts that nothing more is required, as the methodology must only be "reasonable," referring to the language in PRM, Pub. 15-2, § 115.2, quoted above.

The Board finds that the paragraph description of the issue, in which the Provider describes the issue and the estimated impact, in conjunction with Worksheet E-4, which demonstrates the calculation of the DGME Penalty, is sufficient to meet the requirements of § 413.24(j)(2) for self-disallowing a specific item. First, the Provider included an estimated reimbursement amount for the specific item which ties to the cost report (as required in § 413.24(j)(2)(i)) and the paragraph description clearly "explain[s] why the provider self-disallowed each specific item (instead of claiming full reimbursement in its cost report for the specific item)" (as required in § 413.24(j)(2)(ii)). Finally, the Provider explained that in their calculation they applied the full FTE cap rather than the weighted cap and all the data points for that calculation are located on Worksheet E-4. Based on these unique circumstances, the Board also finds that the Provider has provided a sufficient "descri[ption of] how the provider calculated the estimated reimbursement amount" for the specific self-disallowed item as required in 42 C.F.R. § 413.24(j)(2)(ii). Accordingly, the Board finds that the Provider met the requirement of § 413.24(j)(2) for self-disallowing the DGME issue in this appeal.

c) No Findings on Compliance with § 413.24(j) Required for Remaining Providers – Barnes Jewish Hospital, St. Joseph's Regional Medical Center, and Hospital for Special Surgery

Since no party to the appeal has questioned, pursuant to § 405.1873(a), whether an appropriate claim was made by the other three Providers, specifically Barnes Jewish Hospital, St. Joseph's Regional Medical Center, and Hospital for Special Surgery, 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 three Providers. As a result, Board review under 42 C.F.R. § 405.1873(b) has not been triggered for these three 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) 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 request that the Board grant EJR as it relates to 42 C.F.R. §§ 413.24(j) and 405.1873.[35] They claim that these regulations contravene

[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).

the Board's authority set forth in 42 U.S.C. § 1395oo. They note that nowhere in that statute is there a requirement that a provider must include a claim for a specific cost on its cost report before payment related to that cost can be addressed by the Board.[36] The Providers recount how the 2008 self-disallowance regulation was held to conflict with the plain text of 42 U.S.C. § 1395oo in *Banner Heart Hosp. v. Burwell*, 201 F. Supp 3d 131, 140 (2016). They argue that the 2016 self-disallowance regulation at 42 C.F.R. 413.24(j) suffers from the same defects that led the *Banner* court to invalidate the 2008 self-disallowance regulation.[37]

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."[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.

However, the Board does not reach this issue because it is not relevant to the 3 Providers for which no substantive claim challenge was filed. For the 2 Providers where such a challenge was filed (as discussed above), the EJR request became moot because there was a factual dispute regarding the Provider's § 413.24(j) compliance that needed resolution and the Board determined that these 2 Providers met the substantive claim requirements of § 413.24(j). Accordingly, the Board denies the EJR request relative to the Providers' challenge to the validity of 42 C.F.R. §§ 413.24(j) and 405.1873.

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[36] *Id.* at 8.
[37] *Id.* at 9-11.
[38] *Id.* at 11-13.
[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 Thursday, July 28, 2022, so a response would have been due no later than 11:59p.m. (Eastern Time) Thursday, August 4, 2022.
[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).

D. 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.

$$\text{WFTE}\left(\frac{\text{UCap}}{\text{UFTE}}\right) = \text{WCap}$$ [42]

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.[43] 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.[44] 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,

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[42] EJR Request at 9-12.
[43] *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.)).
[44] 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].[45]

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.[46] 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."[47] 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[48] (*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.[49]

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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[45] (Emphasis added.)
[46] *See* 62 Fed. Reg. at 46005 (emphasis added).
[47] *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.)).
[48] 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.
[49] 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 on this issue.

E. 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) The Providers appealed cost reporting periods beginning after January 1, 2016, and the Board makes the following findings on two participants pursuant to 42 C.F.R. § 405.1873(b):

    a. University of Missouri Health Care (Provider No. 26-0141) made "an appropriate claim for the specific item" that is the subject of the appeal, as required under 42 C.F.R. § 413.24(j),

    b. Penn State Health Milton S. Hershey Medical Center (Provider No. 39-0256) made "an appropriate claim for the specific item" that is the subject of the appeal as required under 42 C.F.R. § 413.24(j), and

    c. The EJR request challenging the validity of 42 C.F.R. §§ 413.24(j) and 405.1873 is no longer relevant based on the above findings and, accordingly, is denied;

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);

5) 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 in Finding No. 5 properly fall within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR relative to that question. 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:

8/5/2022

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: ***Denial of EJR and Case Closure***
QRS Providence 2006 SSI Fraction Dual Eligible Days CIRP
Case No. 14-3270GC

Dear Mr. Ravindran:

The request for Expedited Judicial Review ("EJR") in the above-referenced appeal was submitted on May 13, 2022, as part of a consolidated EJR request. On June 3, 2022, the Provider Reimbursement Review Board ("Board") issued a letter addressing the status of the EJR Request and Notice of when the 30-day period commences. In that letter, the Board explained that the 30-day period for responding the EJR requests has not yet begun as the Board has not yet completed its jurisdictional review, which is a prerequisite for the Board to grant EJR pursuant to 42 C.F.R. § 405.1842(a)(4)(i).

On June 13, 2022, the Board issued a Request for Information ("RFI") specific to case 14-3270GC requesting that the:

> Group Representative file the information identified above as well as an updated Schedule of Providers for the Providers in Case No. 14-3270GC *within 30 days of this letter's signature date* so that the Board may complete its jurisdictional review based on the updated Schedule of Providers submission. The Board further requires that the **Group Representative modify its EJR request, as necessary, to: (1) address and account for the fact that Case No. 14-3271GC was dismissed which necessarily means that the Providers cannot raise the same issue covered by Case No. 14-3271GC anew in a separate appeal nor pursue duplicate appeals; and (2) establish what the group issue statement is for Case No. 14-3270GC at its formation and how the EJR request is based on that issue statement**.[1]

[1] Board's RFI, at 5 (Jun. 13, 2022) (emphasis added).

Thus, there were 2 parts to the Board's RFI that QRS was to respond in 30 days, namely update the Schedule of Providers with the requested information and to update the EJR request to account for the fact that there was a duplicate appeal, in part or in whole. Further, the Board noted that:

> *Be advised that the above filing deadline is **firm** and, as this request is being made in the context of an EJR request submitted by the Providers, the Board has determined to **exempt** it from the Board Alert 19 suspension of Board-set deadlines*. Accordingly, failure of the Group Representative to file a response to the Board's deadline will result in the Board taking action without the benefit of the Group Representative filing and may result in the **Board taking remedial action such as denial of any re-submitted EJR request and/or dismissal of this CIRP group case**.[2]

The Group Representative filed a response on July 6, 2022, in which it updated the Schedule of Providers ("SOP") and jurisdictional documentation. However, the Group Representative failed to file an updated EJR request that addresses the issue statement for Case No. 14-3270GC at its formation and how the EJR request is based on that issue statement. As discussed below, because the Group Representative's July 6, 2022 response was failed to respond to the 2nd part of the Board's RFI, the Board hereby denies the EJR request and dismisses the group appeal both for the failure of QRS to respond to the Board's RFI and the fact this case was a duplicate appeal.

Issue in Dispute in the EJR Request

> The issue involved in these group appeals is whether the MAC should have excluded from the Medicare fraction non-covered patient days, i.e., days attributable to patients who were enrolled in Medicare and entitled to SSI, but for whom Medicare did not make a payment for their hospital stay, either because that patient's Medicare benefit days were exhausted, or because a third party made payment for that patient's hospital stay. The Providers identified in the Schedules of Providers referenced in section IV. List of Exhibits contend that these non-covered patient days should be excluded from the Medicare fraction. Providers further contend that these non-covered patient days should be treated consistently; that is, they should either be included in both the top and bottom of the SSI fraction. If excluded from both the top and bottom of the SSI fraction the Title XIX eligible days should then be recognized in the numerator of the Medicaid fraction.

[2] *Id*. (Bold and italics emphasis in original; bold and underlined emphasis added).

Board's 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.

42 C.F.R. § 405.1842(d) outlines the requirements of a Provider's request for EJR:

> 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. A provider must submit a request in writing to the Board and to each party to the appeal (as described in § 405.1843 of this subpart), and the request must include –
>
> (1) For each specific matter and question included in the request, an explanation of why the provider believes the Board has jurisdiction under § 405.1840 of this subpart over each matter at issue and no authority to decide each relevant legal question; and
>
> (2) Any documentary evidence the provider believes supports the request.

Consistent with § 405.1842(b), in order to grant EJR, § 405.1842(f)(1) specifies that the Board must find it "has jurisdiction to conduct a hearing on the specific matter at issue" and that the Board "lacks the authority to decide a specific legal question relevant to the specific matter at issue." Similarly, § 405.1842(f)(2) specifies that "[t]he Board must deny EJR for a legal question relevant to a specific matter at issue in a Board appeal if any of the following conditions are satisfied: (i) The Board determines that it does not have jurisdiction to conduct a hearing on the specific matter at issue."

As the Board explained in its June 13, 2022 RFI, the Board needed additional information to determine whether it had jurisdiction over the group issue, and to determine whether EJR was appropriate for the group issue. As the Group Representative did not provide this information to the Board as requested, the Board cannot determine that it has jurisdiction to conduct a hearing on the specific matter and issue and therefore ***denies*** EJR pursuant to §405.1842(f)(2).

Further, the Board indicated in its RFI that failure to file a response to the Board's deadline will result in the Board taking action without the benefit of the Group Representative filing and may result in dismissal of this CIRP group. Consistent with 42 C.F.R. § 405.1868(a)-(b), Board Rule 41.2 (Nov. 2021) permits dismissal or closure of a case on the Board's own motion:

- If it has a reasonable basis to believe that issues have been fully settled or abandoned,

- **Upon failure of the provider or group to comply with Board procedures or filing deadlines**,
- If the Board is unable to contact the provider or representative at the last known address, or
- Upon failure to appear for a scheduled hearing.[3]

Accordingly, pursuant to 42 C.F.R. § 405.1868(a)-(b), the Board exercises its authority to dismiss the appeal for QRS to timely respond to the Board's request for critical jurisdictional information. The Board notes that the Board's RFI was in the context of a pending EJR request and, accordingly, only heighted the need for timely receipt of information within the specified 30-day period.

Moreover, the reason the Board requested the information from QRS was because the instant group appeal is a prohibited duplicate in whole or in part of a prior cases dismissed by the Board. As QRS has failed to timely respond, the Board must presume it is a compete duplicate and this serves as an independent basis to dismiss the case in its entirety.

Accordingly, the Board hereby dismisses Case No. 14-13270GC and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

FOR THE BOARD:

8/5/2022

X Clayton J. Nix

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

cc: John Bloom, Noridian Healthcare Solutions
Wilson Leong, FSS

[3] (Emphasis added).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

James Flynn
Bricker & Eckler LLP
100 South Third Street
Columbus, OH 43215

RE: ***Jurisdictional Decision***
Pomerene Hospital (36-0148)
FYE: 12/31/2013
PRRB Case: 17-0192

Dear Mr. Flynn,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal and finds that it does not have jurisdiction over the Reduction to Medicare Advantage Days issue. The jurisdictional decision of the Board is set forth below.

Pertinent Facts:

The Board received the Provider's Appeal Request dated October 25, 2016, related to an NPR dated April 25, 2016.[1] The Provider's Appeal Request contained the following issue statement:

> *Issue 1: Reduction to Provider's Medicare Advantage Days*
> ….
> *In auditing the Provider's FY 2013 cost report, the MAC made an adjustment to the Provider's statistics for the number of Medicare Advantage inpatient days provided during the year. The MAC adjusted the statistic to zero, which is an inaccurate reflection of the number of days actually provided. Because that statistic may implicate other payments the Provider is entitled to receive during FY 2013, the Provider wishes to correct the number of Medicare Advantage days based on documentation supporting the number claimed on the cost report.*[2]

The MAC filed a formal Jurisdictional Challenge on April 25, 2018, to which the Provider filed no response.

Medicare Contractor's Jurisdictional Challenge

The MAC argues that the Board does not have jurisdiction of the only issue included in this case as it is duplicated in another appeal, PRRB Case No. 17-0193.[3] While it is conceded in the instant case that the

[1] Provider's Request for Appeal (Oct. 25, 2016).
[2] Provider's Statement of the Issue (Oct. 25, 2016).
[3] MAC's Jurisdictional Challenge, at 2. (Apr. 25, 2018).

Provider is appealing adjustment #2 via the NPR, the MAC argues the Provider is not appealing a financial impact from the NPR, but rather a "downstream adjustment", namely the EHR Incentive Payment.[4] The issue in dispute is the offset of all 734 Medicare Advantage Days on its cost report resulting in EHR Incentive Payment Overpayment of ($385,082).[5]

The MAC argues the issue was briefed and argued in a hearing held on January 17, 2017, before the PRRB and decided in PRRB Decision No. 2018-D4.[6] Additionally, the MAC contends:

> PRRB Cases No. 17-0193 and 17-0192 dispute the same cost report (36-0148 12/31/13) for the same issue which offset all 734 Medicare Advantage Days on its cost report. Both cases have the same amount in controversy $385,082. Both cases seek the same remedy, the reversal of the MAC's offset of all 734 Medicare Advantage days.[7]

Filing a duplicate appeal is a violation of PRRB Rule 4.5 founded in 42 C.F.R. § 405.1801(a)(3).[8]

Board's Decision:

The Board finds that the issue in the instant case is duplicative of the issue in PRRB Case No. 17-0193. In Case No. 17-0193,[9] the Provider appealed the EHR Incentive Payment Settlement. At issue in that case was the MAC's calculation, which included the offset of all 734 Medicare Advantage Days on the cost report. Both cases substantively focus on this issue. The cases have the same amount in controversy and the same remedy is sought. The Board finds the issues are duplicative which is barred by Board Rules. Therefore, the Board does not have jurisdiction over the Reduction to Medicare Advantage Days issue in the above-referenced appeal because jurisdiction is precluded by PRRB Rule 4.5[10] and 42 C.F.R. § 405.1835(b)(4)(i).[11]

Conclusion

Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited, the Board dismisses the issue from the appeal. As there are no other issues in this appeal, the appeal is dismissed.

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

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[4] *Id*.
[5] *Id*. and Exhibit I-1.
[6] *Id*. at 3. Note: The Board found that the MAC properly calculated the Provider's EHR incentive payments for 2012 and 2013 based on the methodology in 42 C.F.R. § 495.104. *See* MAC's Exhibit I-2.
[7] *Id.*
[8] *Id*. at 3. *See* PRRB Rule 4.5 (v. 1.3, 2015).
[9] **Note:** Case 17-0193 was briefed and argued on Jan. 17, 2017. The Case was decided in PRRB Decision No. 2018-D4.
[10] (v. 1.3, 2015).
[11] (Jan. 2016).

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:

8/5/2022

X Kevin D. Smith, CPA

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kathleen Giberti
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Lorraine Frewert, JE Prov. Audit
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Determination***
St. Mary Medical Center (Prov. No. 05-0300)
FYE 06/30/2016
Case No. 22-0729

Dear Ms. Giberti and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On June 9, 2020, the Provider requested reopening of its FYE 6/30/2016 cost report to "request[] recalculation of its SSI ratio based on its cost reporting period rather than the federal fiscal year."

On April 13, 2021, the Medicare Administrative Contractor ("MAC") issued the Notice of Reopening,[1] in which it advised that the cost report was being reopened, in pertinent part, "[t]o adjust the SSI ratio used to calculate the providers disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."[2]

On August 19, 2021, the MAC issue the Notice of Amount of Corrected Reimbursement ("RNPR"[3]).[4] The Audit Adjustment Report for the RNPR had 5 adjustments and only one pertained to DSH, namely Audit Adjustment No. 4 "To revise the SSI Ratio and the Allowable DSH %, which is based on the CMS Letter for SSI% ***Realignment***."[5]

[1] Medicare Contractor's Notice of Reopening of Cost Report.
[2] *Id.*
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] Provider's Request for Individual Appeal, at 2
[5] (Emphasis added.)

On February 9, 2022, St. Mary Medical Center ("Provider") filed the individual appeal from the RNPR[6] and the Board assigned the appeal to Case No. 22-0729. The RNPR appeal included two (2) issues:

> DSH Accuracy of CMS Developed SSI Ratio
> DSH Inclusion of Medicare Part C Days in the SSI Ratio[7]

The Provider referenced Audit Adjustment No. 4 for the issues appealed from the RNPR. Audit Adjustment No. 4 was issued "[t]o revise the SSI Ratio and the Allowable DSH % which is based on the CMS Letter for SSI% ***Realignment***."[8]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), 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 (or $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 Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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)[9] explains the effect of a cost report revision:

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[6] *Id.,* at 1.
[7] *Id.*, at 3.
[8] Audit Adjustment Report (emphasis added).
[9] *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).

> (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.

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[10] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. 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 -

[10] 42 C.F.R. § 405.1889(b)(1).

> (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)).[11]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[12] 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***."[13]

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*

[11] (Emphasis added.)
[12] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[13] (Emphasis added.)

> *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."[14]

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 DSH Accuracy of CMS Developed SSI Ratio issue and the DSH Inclusion of Medicare Part C Days in the SSI Ratio issue in the individual appeal.[15] 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.[16]

In conclusion, the Board ***dismisses*** the two issues appealed from the RNPR in Case No. 22-0729 because, pursuant to 42 C.F.R. § 405.1889(b), the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 22-0729 and removes it from the Board's docket.

---

[14] (Emphasis added.)
[15] The Board notes that the Provider could have appealed these issues from its original NPR but appears to have forewent that opportunity.
[16] *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).

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

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

FOR THE BOARD:

8/5/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Kathleen Giberti
Toyon Associates, Inc.
1800 Sutter Street, Suite 600
Concord, CA 94520-2546

Lorraine Frewert
Noridian Healthcare Solutions
P.O. Box 6782
Fargo, ND 58108-6782

RE: ***Jurisdictional Determination***
St. Joseph Hospital (Prov. No. 05-0006)
FYE 06/30/2017
Case No. 22-1104

Dear Ms. Giberti and Ms. Frewert,

The Provider Reimbursement Review Board ("Board") has reviewed the above-captioned appeal and finds an impediment to the Board's jurisdiction. The pertinent facts and the Board's jurisdictional determination are set forth below.

Background

On March 22, 2021, the Provider submitted a request to the Medicare Administrative Contractor ("MAC") to have its SSI ratio recalculated based on its cost reporting period rather than the federal fiscal year.

On April 30, 2021, the MAC issued the Notice of Reopening,[1] in which it advised that the cost report was being reopened "[t]o adjust the SSI ratio used to calculate the providers [sic] disproportionate share adjustment based on the data from the hospital's actual cost reporting period rather than the federal fiscal year and to amend the disproportionate share adjustment to account for the change in SSI ratio."[2]

On December 15, 2021, the MAC issued the Notice of Amount of Corrected Reimbursement ("RNPR"[3]).[4] Audit Adjustment No. 5 was the "[a]djustment made to revise the SSI Ratio and the allowable DSH % based on the latest CMS Letter of SSI% ***Realignment***."[5]

[1] Medicare Contractor's Cost Report Reopening and SSI Ratio Realignment Request.
[2] *Id.*
[3] Hereafter, the Notice of Amount of Corrected Program Reimbursement will be referred to as a revised Notice of Program Reimbursement ("RNPR").
[4] Reopened Settlement for Providence St Joseph Hospital, Notice of Amount of Corrected Program Reimbursement, at 1.
[5] (Emphasis added.)

On June 9, 2022, St. Joseph Hospital - Eureka ("St. Joseph" or "Provider") filed the individual appeal from the RNPR[6] and the Board assigned the appeal to Case No. 22-1104. The appeal included two (2) issues:

> DSH – Accuracy of CMS Developed SSI Ratio
> DSH – Inclusion of Medicare Part C Days in the SSI Ratio[7]

The Provider referenced Audit Adjustment No. 5 for both issues appealed from the RNPR. Adjustment #5 was issued to "revise the SSI Ratio and the allowable DSH % based on the latest CMS Letter of SSI% ***Realignment***."[8]

Board Determination

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2019), 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 (or $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 Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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)[9] explains the effect of a cost report revision:

---

[6] *Id.*, at General Information.
[7] *Id.*, at Issue Statement.
[8] Audit Adjustment Report (emphasis added).
[9] *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).

> (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.

The Board finds that it does not have jurisdiction over the two issues in this individual appeal filed from the RNPR because the RNPR was issued as a result of the Provider' SSI Realignment request. As a result, the Provider does not have the right to appeal under 42 C.F.R. § 405.1889(b) as referenced in § 405.1835(a)(1).

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[.]"[10] The reopening in this case was a result of the Provider's request to realign its SSI percentage from the federal fiscal year end to its individual cost reporting fiscal year end. 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 -

[10] 42 C.F.R. § 405.1889(b)(1).

> (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)).[11]

The data matching process by which CMS gathers this *monthly* data is described in the FY 2011 IPPS Final Rule.[12] 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***."[13]

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*

[11] (Emphasis added.)
[12] 75 Fed. Reg. 50042, 50275-85 (Aug. 16, 2010).
[13] (Emphasis added.)

> *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."[14]

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 Accuracy of CMS Developed SSI Ratio issue and the Inclusion of Medicare Part C Days in the SSI Ratio issue in the individual appeal.[15] 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.[16]

In conclusion, the Board ***dismisses*** the 2 issues appealed from the RNPR in Case No. 22-1104 because, pursuant to 42 C.F.R. § 405.1889(b), the Provider does not have the right to appeal the RNPR at issue for these issues. As there are no remaining issues in the individual appeal, the Board hereby closes Case No. 22-1104 and removes it from the Board's docket.

---

[14] (Emphasis added.)
[15] The Board notes that the Provider could have appealed these issues from its original NPR but appears to have forewent that opportunity.
[16] *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).

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

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

FOR THE BOARD:

8/5/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Ronald Rybar
The Rybar Group, Inc.
3150 Owen Road
Felton, MI 48430

Scott Berends, Esq.
Federal Specialized Services
1701 S. Racine Avenue
Chicago, IL 60608-4058

RE: ***Request for Reconsideration of PRRB Decision 2022-D19 Decision***
Skiff Medical Center (Prov. No. 16-0032)
FYE 06/30/2011
Case No. 15-3335

Dear Mr. Rybar and Mr. Berends,

The Provider Reimbursement Review Board ("Board") has reviewed the Request for Reconsideration of PRRB Dec. No. 2022-D19 that Skiff Medical Center ("Skiff") filed on May 24, 2022. The Board's decision to deny Skiff's request for reconsideration is set forth below.

Background:

42 C.F.R. § 412.108(d) addresses the additional payment that Medicare dependent hospitals ("MDHs") may seek after experiencing a significant volume decrease:

> (d) *Additional payments to hospitals experiencing a significant volume decrease*. (1) CMS provides for a payment adjustment for a Medicare-dependent, small rural hospital for any cost reporting period during which the hospital experiences, due to circumstances as described in paragraph (d)(2) of this section, **a more than 5 percent decrease in its total inpatient discharges as compared to its immediately preceding cost reporting period**. . . .
>
> (2) To qualify for a payment adjustment on the basis of a decrease in discharges, a Medicare-dependent, small rural hospital **must submit its request no later than 180 days after the date on the MAC's Notice of Amount of Program Reimbursement** and it must -
>
> (i) Submit to the MAC documentation demonstrating the size of the decrease in discharges and the resulting effect on per discharge costs; and
>
> (ii) **Show that the decrease is due to circumstances beyond the hospital's control**.

> (3) The MAC determines a lump sum adjustment amount in accordance with the methodology set forth in § 412.92(e)(3).
>
> (i) **In determining the adjustment amount, the MAC considers** -
>
> (A) The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
>
> (B) The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
>
> (C) The length of time the hospital has experienced a decrease in utilization.
>
> (ii) The MAC makes its determination within 180 days from the date it receives the hospital's request and all other necessary information.
>
> (iii) **The MAC determination is subject to review under subpart R of part 405 of this chapter**. The time required by the MAC to review the request is considered good cause for granting an extension of the time limit for the hospital to apply for that review.[1]

As such, MDHs right to appeal a VDA determination to the Board occurs outside the cost report and NPR and is a creature of regulation.

On September 16, 2015, Skiff filed its appeal request with the Board The Board approved Case No. 15-3335 for a Record Hearing on April 6, 2021. The Board issued the PRRB Dec. No. 2022-D19 on April 27, 2022. On May 24, 2022, the Provider submitted a Request for Reconsideration of PRRB Dec. No. 2022-D19. The issue before the Board in Case No. 15-3335 was whether the Provider *qualified* to have a Volume Decrease Adjustment (VDA) calculation performed. Pursuant to 42. C.F.R. § 412.108(d)(3)(iii), a Medicare contractor's VDA "***determination*** is subject to [Board] review under subpart R of part 405 of this chapter." Accordingly, the Board found it had jurisdiction in this case as a result of the original VDA denial and the reconsideration denial. Both determinations contend that Skiff *failed* to meet the 5 percent decrease in discharges between years "due to an unusual event or occurrence beyond the Provider's control."[2] However, ***neither*** the original VDA determination ***nor*** the reconsideration that were at issue, included a formal Medicare Contractor determination on the amount Skiff would be due under § 412.108(d)(3) if it were eligible for a VDA adjustment. Similarly, the appeal request filed by Skiff did ***not*** raise the *methodology* for the VDA calculation as a disputed item for appeal, presumably because the Medicare Contactor had not yet had to issue a determination on a VDA calculation since it had determined that Skiff did not qualify for a VDA adjustment.

Consistent with 42 U.S.C. 1395ww(d)(5)(G)(iii) *and* based upon the Board's finding of jurisdiction, the parties' stipulations, the parties' agreement to conduct a hearing on record, and the record before the

[1] (Bold emphasis added.)
[2] Medicare Contractor's FPP at 6.

Board, the Board accepted Stipulation ¶ 5 and found that Skiff was eligible for a VDA calculation for FY 2011 and, consistent with § 412.108(d)(3) (2012), the Medicare Contactor must take into account multiple factors, including but not limited to "the individual hospital's needs and circumstances," when making this calculation. Accordingly, the Board remanded this appeal to the Medicare Contractor with direction to perform a VDA calculation consistent with § 412.108(d)(3) (2012) and, if indicated by the calculation, to make an additional VDA payment for FY 2011.

Provider's Brief in Support of Request for Reconsideration:

The Provider argues that the Medicare Contractor did in fact perform a VDA calculation as sets forth in Exhibit C-1. Exhibit C-1 is a workpaper from the Medicare Contractor dated March 24, 2015 which was prior to the original VDA determination dated April 2, 2015 and the reconsideration determination dated May 28, 2015.

The Provider also states that "Provider and MAC stipulated to the FY2011 VDA calculation in their Record Hearing Request with Signed Stipulations. … The parties respectfully request reconsideration regarding the remand of the appeal to the MAC to perform the VDA calculation for FY2011 …[3]

Board Decision:

42 C.F.R. § 405.1871(b) states:

> (1) A Board hearing decision issued in accordance with paragraph (a) of this section is final and binding on the parties to the Board appeal unless the hearing decision is reversed, affirmed, modified, or remanded by the Administrator under §§ 405.1875(a)(2)(i), 405.1875(e), and 405.1875(f) of this subpart, no later than 60 days after the date of receipt by the provider of the Board's decision.
>
> (2) A Board hearing decision is inoperative during the 60-day period for review of the decision by the Administrator, or in the event the Administrator reverses, affirms, modifies, or remands that decision within the period.
>
> (3) A Board hearing decision that is final under paragraph (b)(1) of this section is subject to the provisions of § 405.1803(d) of this subpart, unless the decision is the subject of judicial review (as described in § 405.1877 of this subpart).
>
> (4) ***A final Board decision*** *under paragraph (a) and (b)* of this section may be reopened and revised by the Board in accordance with §§ 405.1885 through 405.1889 of this subpart.

[3] Reconsideration Request at 1. (May 24, 2022)

> (5) When the contractor's denial of the relief that the provider seeks before the Board is based on procedural grounds (for example, the alleged failure of the provider to satisfy a time limit) or is based on the alleged failure to supply adequate documentation to support the provider's claim, and the Board rules that the basis of the contractor's denial is invalid, the Board (6) remands to the contractor for the contractor to make a determination on the merits of the provider's claim**.**

According to this regulation, the Board may not modify its decision until 60 days have elapsed following the issuance of the decision. Accordingly, the Board's decision became final on Friday, July 1, 2022.[4]

The Board hereby denies the Provider's reconsideration request. It was proper for the Board to remand this appeal under 42 C.F.R. § 405.1871(b)(5). The facts remain the same in that the Medicare Contractor did *not* make and issue a ***determination*** on the VDA calculation pursuant to 42 C.F.R. § 412.108(d)(3)(ii).[5] Additionally, the Provider's reconsideration request does not include any arguments as to *why* the Board should not have remanded the issue to the Medicare Contractor, and what relief it is seeking instead.

Board Members:

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

For the Board:

8/8/2022

X Clayton J. Nix

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

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

[4] The Administrator's receipt of the Board's decision is presumed to be 5 days after its issuance. As a result, the Board's decision did not become final until Friday, July 1, 2022.

[5] The workpaper at Exhibit C-1 is not a determination and was not finalized and issued to the Provider with appeal rights. Examples of recent VDA cases where the Board has remanded back to the Medicare contractor include: *Grinnell Reg'l Med. Ctr. v. Wisconsin Physicians Serv.*, PRRB Dec. 2016-D03 (Dec. 1, 2015); *Alta Vista Reg'l Hosp. v. Wisconsin Physicians Serv.*, PRRB Dec. 2015-D9 (May 12, 2015); *Porter Hosp. Middlebury, Vt. v. Blue Cross & Blue Shield Ass'n*, PRRB Dec. 2013-D34 (Aug. 29, 2013); *Rice Mem'l Hosp. v. National Gov. Servs.*, PRRB Dec. 2018-D51 (Sept. 28, 2018); *St. Mary's Reg'l Hosp. v. National Gov. Servs.*, PRRB Dec. No. 2018-D52 (Sept. 28, 2018).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

David Johnston, Esq.
Epstein Becker & Green, PC
375 N. Front St. Ste. 325
Columbus, OH 43215

Judith Cummings
CGS Administrators
CGS Audit & Reimbursement
P.O. Box 20020
Nashville, TN 37202

RE: ***Jurisdictional Decision***
OhioHealth Corporation 2010 Dual Elig CIRP Group
PRRB Case No. 14-3067GC

Dear Mr. Johnston and Ms. Cummings:

The Provider Reimbursement Review Board ("Board" or "PRRB") has reviewed the documents in Case No. 14-3067GC and finds that it does not have jurisdiction over two participants in the common issue related party ("CIRP") group. The Board's Decision is set forth below.

Background

Case No. 14-307GC was established on March 26, 2014 for the OhioHealth Corporation 2010 Dual Eligible group. On November 21, 2019, the Board issued a Notice of Own Motion Expedited Judicial Review ("EJR") in which it indicated that it was considering EJR for the Part C days issue. In addition to comments related to the own motion EJR, the Board also requested that the Providers' representative submit an updated Schedule of Providers ("SOP") and associated jurisdictional documentation. The Group Representative submitted the SOP on December 20, 2019, with seven (7) Providers. The Board finds that it does not have jurisdiction over Participants 6 and 7 on the SOP, as discussed below.

Board's Decision

The SOP shows that Participant 6, Marion General Hospital, and Participant 7, Riverside Methodist Hospital, transferred from individual appeal that were established based on a revised NPR. However, the Group Representative failed to include that documentation even though required under Board Rule 21 governing SOPs. Indeed, the Board has no record of the alleged transfers and previously dismissed those individual appeals in their entirety.

A. Participant 6 – Marion General Hospital

Marion General Hospital (Provider No. 36-0011), was issued a revised Notice of Program Reimbursement ("NPR") on April 24, 2019:

> To realign the SSI% to the amount determined by CMS based on the hospital fiscal year end instead of the federal fiscal year end per your request received on June 25, 2014 and in accordance with 42 CFR 412.106(b)(3).

The Provider filed an appeal with the Board on October 21, 2019, and Case No. 20-0180 was established. On July 23, 2020, the Board dismissed Case No. 20-0180, because the Provider's revised NPR did not adjust the only issue in the appeal, Part C days. The Board found:

> The adjustment included in the revised NPR and that is the subject of this appeal, clearly show it was as a result of SSI realignment that changed the 12-month time period from the FFY ending September 30 to the Provider's cost reporting period. The Provider in this appeal is not challenging that the Medicare Contractor or CMS didn't calculate the realigned SSI ratio correctly for those dates, but instead challenges an aspect of the agency's methodology for counting the days that are reflected in each months data, specifically they challenge the inclusion of Part C days in the SSI percentage and asserts instead that they should be counted in the Medicaid fraction. CMS does not utilize a new or different data match process when it issues a realigned SSI percentage and, in addition, all of the underlying data (which is gathered on a month-by-month basis) remains the same. The realigned SSI percentage simply reflects a different 12-month time period being used. More specifically, the realignment solely takes the SSI data for each provider and the total Medicare days for each provider (previously accumulated on a month-by-month basis and used in the original CMS published SSI percentages) and reports it on the provider's cost reporting period instead of the September 30 FFY.[1]

The Board found that it did not have jurisdiction over the DSH Part C Days issue, and closed the appeal. Additionally, there is nothing in the record of either Case No. 20-0180 or Case No. 14-3067GC showing that the Provider requested to transfer the issue from the individual appeal under Case No. 20-0180 to the group appeal at issue before the Board. Indeed, Column G on the SOP should list the date of the transfer; however, the SOP states "TBD," *i.e.*, to be determined, confirming that no such transfer was ever filed. Finally, even if there had been a transfer prior to that dismissal, the basis for the dismissal of the individual appeal would be equally applicable here. Accordingly, the Board finds that Marion General Hospital was never a part of this group and is inappropriately listed on the SOP.

B. Participant 7 – Riverside Methodist Hospital

Similarly, Participant 7, Riverside Methodist Hospital (36-0006) filed an appeal from a revised NPR which was issued:

[1] Board Jurisdictional Decision at 4 (internal citations omitted).

> To update the SSI % based on the hospital fiscal year end instead of the federal fiscal year end in accordance with 42 CFR 412.106(b)(3) and the Provider's request received 6/25/2014.

The Provider filed an appeal request with the Board on December 19, 2019, and Case No. 20-0532 was established. On July 23, 2020, the Board dismissed the Provider's appeal of the Part C issue in its individual appeal, Case No. 20-0532, based on the same rationale as its dismissal of Case No. 20-0180: the revised NPR was issue for SSI realignment, and thus the Provider's revised NPR did not specifically adjust Part C days. Additionally, there is nothing in the record of either Case No. 20-0532 or Case No. 14-3067GC showing that the Provider requested to transfer the issue from the individual appeal to the group appeal at issue before the Board. Even if there had been a transfer prior to that dismissal, the basis for the dismissal of the individual appeal would be equally applicable here. Accordingly, the Board finds that **Participant 7**, Riverside Methodist Hospital, was never a part of this group and is inappropriately listed on the SOP.

Finally, the Board notes that Riverside Methodist Hospital has also appealed from an original NPR, which remains pending in the group appeal ***as Participant 5*** based on the original NPR appeal.

****

In summary, the Board dismisses/removes Participant 6, Marion General Hospital, and Participant 7, Riverside Methodist Hospital because, notwithstanding the requirements for SOPs in Board Rule 21, there is no record in the SOP (or the relevant cases) of those providers having transferred to this group and the Board previously dismissed, in their entirety, the individual appeals from which they were allegedly transferred.

Case No. 14-3067GC remains open and will be remanded pursuant to CMS Ruling 1739-R under separate cover. 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 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:

8/8/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS

Enclosure: Attachment A – Schedule of Providers

Attachment A

1A 1B 1D 1H 2A 2B 2D 2G 2H 3A

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PROVIDER REIMBURSEMENT REVIEW BOARD

Model Form G: Schedule of Providers in Group

Case No. 14-3067GC
Group Name: ViewHealth Corporation 2010 Dual-Elig CIRP Group
Group Representative: David M. Johnston
Lead Intermediary: CGS Administrators, LLC ("CGS")
Issue: Disproportionate Share Adjustment/Inclusion of Appropriate Dual-Eligible (Part C) Days in the Calculation of the Providers' DSH Percentage

Page 1 of 1
Date Prepared: December 19, 2019

	Provider Number	Provider Name/Location (city, county, state)	FYE	Intermediary/ MAC	A Date of Final Deter-mination	B Date of Hearing Request/ Add Issue	C No. of Days	D Audit Adj. No.	E Amount in Controversy	F Prior Case No(s).	G Date of Direct Add/ Transfer(s) to Group
1.	36-0152	Doctors Hospital (Columbus, Ohio)	6/30/10	CGS Administrators, LLC ("CGS")	10/2/13	3/25/14	174	16	$151,717	N/A	4/17/14 (formation)
2.	36-0348	Dublin Methodist Hospital (Dublin, Ohio)	6/30/10	CGS	8/21/13	2/12/14 4/17/14	175 239	15	$12,516	14-2411	4/17/14
3.	36-0210	Grady Memorial Hospital (Delaware, Ohio)	6/30/10	CGS	8/21/13	2/12/14 4/17/14	175 239	14	$10,385	14-2413	4/17/14
4.	36-0017	Grant Medical Center (Columbus, Ohio)	6/30/10	CGS	8/14/13	2/7/14 4/10/14	177 236	16	$305,476	14-2334	4/9/14
5.	36-0006	Riverside Methodist Hospital (Columbus, Ohio)	6/30/10	CGS	2/19/14	8/15/14	177	22	$251,685	N/A	8/15/14
* 6.	[redacted]	Marion – Revised NPR	6/30/10	CGS	4/24/19	10/21/19	188	1	$97,687	20-0180	TBD
* 7.	[redacted]	RMH – Revised NPR	6/30/10	CGS	7/24/19	12/19/19	148	1	$1,184,901	20-0522	See Note 2

Total $ 1,931,457

Note 1 – In accordance with Board Rules 5.4 and 21.9, the Notice of Appointment of Representative is attached as item 1-H.

Note 2 – Provider 36-0006 has appeals from both its original NPR and revised NPR of this issue. At the direction of Board staff, we have appealed and listed both appeals in the schedule of providers. The appeal from the revised NPR deals with a DSH calculation period on the Provider's fiscal year rather than the federal fiscal year.

Note 3 – The Group is aware of two other common issue related party providers who have requested DSH calculation realignments, and intend to appeal the Group issue from their respective revised NPRs and join the Group.

Note: The two providers with RNPRs have been removed from the SOP as noted below for lack of jurisdiction as they were never transferred into this case and the original cases were dismissed for lack of jurisdiction

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Nan Chi
Houston Methodist Hospital System
8100 Greenbriar, GB 240
Houston, TX 77054

RE: ***Jurisdictional Decision***
Houston Methodist West Hospital (Prov. No. 67-0077)
FYE 12/31/2017
Case No. 21-0330

Dear Ms. Chi,

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

Pertinent Facts:

On December 7, 2020, the Board received Provider's Individual Appeal Request appealing their July 2, 2020 Notice of Program Reimbursement ("NPR") for fiscal year ending December 31, 2017. The initial appeal contained the eight (8) following issues:

- Issue 1: Disproportionate Share Hospital (DSH) Supplemental Security Income (SSI) Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage (Systemic Errors)
- Issue 3: DSH Medicare Part C Pays
- Issue 4: DSH Medicare Dual Eligible Days
- Issue 5: DSH Medicaid Eligible Days
- Issue 6: DSH Medicaid Part C
- Issue 7: DSH Medicaid Dual Eligible Days
- Issue 8: Standardized Payment Amount[1]

On December 8, 2020, the Provider transferred issues 2, 3, 4, 6, 7, and 8 to groups.[2] Issue 2, DSH Systemic Errors, was transferred to PRRB Case No. 20-1609GC.[3] And on May 19, 2021,

[1] Provider's Request for Individual Appeal, at Appeal Issues.
[2] Model Form D- Provider's Request to Transfer Issue.
[3] *Id.*

Issue 5 was withdrawn.[4] After these transfers and withdrawal, Issue 1 is the remaining issue on appeal.

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

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

Similarly, the Provider described Issue 2, the DSH/SSI (Systemic Errors) issue, which has been transferred to Case Number 20-1609GC, as follows:

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

[4] PRRB's Withdrawal of Issue notification.
[5] Provider's Preliminary Position Paper, at 1-2.

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

While the parties have yet to file their Final Position Papers, the Provider additionally presented its position on Issue 1 in its Jurisdictional Response paper, filed on December 14, 2021.[7]

> **SSI Provider Specific Issue**
>
> Provider is not addressing the errors which result from CMS' improper data matching process but is addressing the various errors of omission and commission that do not fit into the "systemic errors" category. In Baystate, the Board also considered whether, independent of these systemic errors, whether Baystate's SSI fractions were understated due to the number of days included in the SSI ratio. *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008). The Provider has analyzed Medicare Part A records and has been able to identify patients believed to be entitled to both Medicare Part A and SSI. The Provider has reason to believe that the SSI percentage determined by CMS is incorrect due to the understated days in the SSI ratio. Therefore, the Board should find jurisdiction over the SSI provider specific issue in the instant appeal.[8]

On November 23, 2021, the Board received a jurisdictional challenge filed on behalf of the Medicare Contractor which argued that the Board lacks jurisdiction over Issue 1 (the DSH/SSI (Provider Specific) issue) because it is duplicative of Issue 2 (the DSH/SSI (Systemic Errors) issue), which was transferred to Case 20-1609GC.[9]

Board Decision:

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

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[6] *Id* at Issue 2.
[7] Provider's Jurisdictional Response, at 1.
[8] *Id.* at 2.
[9] MAC's Jurisdictional Challenge, at 1.

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

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

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

A. Issue 1

The Board finds that the first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH/SSI (Systemic Errors) issue that was transferred to Group Case No. 20-1609GC.

Issue 1 in the present appeal concerns "whether the Medicare Administrative Contractor used the correct [SSI] percentage in the [DSH] Calculation."[10] The Provider's legal basis for this aspect of Issue 1 is simply that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] Similarly, the Provider argues that "it[s] SSI percentage published by [CMS] was incorrectly computed . . ." and it ". . . [s]pecifically . . . disagrees with the MAC's calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12] Issue 2 that was transferred to a group under Case No. 15-3319GC similarly alleges that the Medicare Contractor and CMS improperly calculated the DSH/SSI Percentage, the DSH/SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F)(i).[13]

In making this finding, the Board further notes that CMS' regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case No. 20-1609GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider's reliance upon referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be

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

distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 20-1609GC.

Accordingly, the Board must find that Issue 1 and Issue 2, which was transferred to Group Case No. 20-1609GC, are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue. In the alternative, the Board would dismiss Issue 1 due to the Provider's failure to properly brief the issue in its FPP in compliance with Board Rules.

B. Second Aspect of Issue 1

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

Conclusion:

The Board dismisses Issue 1, the DSH/SSI (Provider Specific) issue, in its entirety from this appeal. Case No. 21-0330 is closed since there are no remaining issues in this appeal. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/8/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., Federal Specialized Services
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert L. Roth, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Suite 550
Washington, D.C. 20004

Bernard M. Talbert, Esq.
Federal Specialized Services
1701 S. Racing Avenue
Chicago, IL 60608-4058

RE: ***Closure of Cases & Suspension of Jurisdictional & Substantive Claim Processes***
Standardized Amount Base Rate Accuracy Groups for FFYs 2019, 2020, 2021
Case Nos. 19-0849GC, 20-1432G, 20-1494GC, 21-0803G

Dear Messrs. Roth and Talbert:

As the parties are aware, Hooper, Lundy and Bookman ("HLB"), the Providers' designated representative, filed requests for expedited judicial review ("EJR") with the Provider Reimbursement Review Board ("Board") on April 8, 2022 for the above-referenced group cases in connection with the following allegation regarding the standardized amount[1] *as used* ***in the payment rates*** *for inpatient prospective payment system* ("IPPS") ***during*** *federal fiscal years ("FFY") 2019, 2020, and 2021*:

> CMS's treatment of transfers as discharges for the purpose of rate-setting in FFY 1984 caused an understatement of its "average cost per discharge" calculation and the resulting FFY 1984 standardized amount***s***, which led to IPPS underpayments from FFY 1984 to this day because the standardized amount***s*** in each FFY are based on the standardized amount***s*** from the prior FFY ***with certain percentage adjustments***.[2]

It has come to the Board's attention that the Providers' have filed a complaint in federal district court[3] to pursue the merits of their EJR requests, notwithstanding the fact that the Board has not yet completed its jurisdictional and substantive claim reviews and not yet issued a determination on the EJR requests. As set forth in more detail below, the Board hereby takes the following actions consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1[4]:

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[1] 42 U.S.C. §§ 1395ww(d)(2)(D) and (d)(3) required that the Secretary compute two average standardized amounts for discharges occurring during a fiscal year—one for hospitals in large urban areas and another for hospitals in other areas. However, beginning for discharges on after April 1, 2003 those standardized amounts were equalized to arrive at one rate. *See* 69 Fed. Reg. 48916, 49077-78 (Aug. 11, 2004). This change was effectuated through a series of legislation, namely Consolidated Appropriations Resolution, 2003, Pub. Law 108-7, § 402(b), 117 Stat. 11, 548 (2003); Pub. Law 108-89, § 402, 117 Stat. 1131, 1134-36 (2003) (includes provision for certain preclusion of administrative or judicial review); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. Law 108-173, § 401, 117 Stat. 2066, 2262-64 (2003).

[2] Second EJR Request at 4 (Apr. 8, 2022) (citations omitted) (emphasis added).

[3] *See infra* note 31.

[4] 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.

1. Closes these 4 group cases; and

2. Suspends completion of:

   - The ongoing jurisdictional review process, including but not limited to, the Board-initiated review of substantive jurisdiction examining, in part, whether 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the FFY 1984 standardized amount***s***[5] for IPPS as adopted in the interim final rule published on September 1, 1983[6] because the FFY 1984 standardized amount***s*** are (from a backward-looking perspective) inextricably tied to[7] an unreviewable agency action, namely the FFY 1984 and 1985 budget neutrality adjustments at 42 U.S.C. § 1395ww(e)(1)(B) which are a "proportional adjustment in *applicable percentage increase*"[8] and are precluded from administrative and judicial review pursuant to § 1395ww(d)(7)(A); and

   - The ongoing substantive claim review process under 42 C.F.R. § 405.1873(b) which was triggered by "Substantive Claim Challenges"[9] filed in Case Nos. 20-1432G regarding 6 participants (3 of which require resolution of factual disputes[10]) and in Case No. 21-0803G regarding 3 participants (2 of which require resolution of factual disputes[11]) and, as a result, must issue findings pursuant to § 405.1873(d)(2) on these participants'

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[5] As discussed more fully at *supra* note 1, when IPPS was implemented, the statute required multiple standardized amounts and now there is just one equalized standardized amount.

[6] 48 Fed. Reg. 39752, 39838 (Sept. 1, 1983).

[7] *See Florida Health Sciences Center, Inc v. Sec'y of Health & Human Servs*., 830 F.3d 515, 521 (D.C. Cir. 2016) (citing to Texas Alliance for Home Care Servs. v. Sebelius, 681 F.3d 402 (D.C. Cir. 2012) (stating "The critical factor in *Texas Alliance* was not whether the statute barred from review the agency's ultimate determination or merely an intermediate step in reaching that decision. Rather, we were concerned with the close connection between the element being challenged and the decision that could not be challenged in court. *Texas Alliance*, 681 F.3d at 409–11. That analysis applies with equal force here. The dispositive issue is whether the challenged data are inextricably intertwined with an action that all agree *is* shielded from review, regardless of where that action lies in the agency's decision tree. Because the data here are inextricably intertwined with the Secretary's estimate of uncompensated care, Tampa General cannot challenge the Secretary's choice of data in court.").

[8] 42 U.S.C. § 1395ww(e)(emphasis added). Section 1395ww(e) is entitled "Proportional adjustment in *applicable percentage increases*." (Emphasis added.) The FFY 1984 and 1985 budget neutrality adjustments in § 1395ww(e)(1)(B) were made ***to the standardized amount*****s** to ensure that aggregate payments for those years under IPPS "are not greater ***or*** less than" what would have been paid without IPPS. 42 U.S.C. § 1395ww(e)(1)(B)(emphasis added). Moreover, the FFY 1984 and 1985 budget neutrality adjustments would appear to serve as the "applicable percentage increase" for FFY 1984 and 1985 since no "applicable percentage increase" is provided for those years in 42 U.S.C. § 1395ww(b)(3)(B) as cross referenced in §§ 1395ww(d)(2)(B)(ii) for FFY 1984 and 1395ww(d)(3(A) for FFY 1985 and forward. In this regard, the "applicable percentage increase" ***as used in § 1395ww(d)*** is defined at § 1395ww(b)(3)(B)(i) *but only for FFYs 198****6*** *forward*.

[9] As explained 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" ***as required*** *by 42 C.F.R. § 413.24(j)*.

[10] HLB's March 4, 2022 response to the Substantive Claim Challenge filed in Case No. 20-1432G: (1) disputed the lead Medicare Contractor's claim that Berkshire Medical Center, Good Samaritan Hospital, and Elliot Hospital of the City of Manchester failed to properly self-disallow; and (2) included certain additional documentation in support.

[11] HLB's June 6, 2022 response to the Substantive Claim Challenged filed in Case No. 21-0803G: (1) disputed the lead Medicare Contractor's claim that Oroville Hospital and Milford Regional Medical Center failed to properly self-disallow; and (2) included certain additional documentation in support of their position.

compliance with the "appropriate cost report claim" requirements in § 413.24(j), *if the Board were to find jurisdiction and issue an EJR decision*.[12]

Procedural Background:

HLB initially filed an EJR request for Case Nos. 19-0849GC and 20-1432G on August 10, 2020. Federal Specialized Services ("FSS") filed a jurisdictional challenged in response to the EJR request in Case No. 19-0849GC. Upon review, the Board considered the issues raised in the jurisdictional challenge to be applicable to all standardized amount appeals and, as a result, issued a Request for Information ("RFI") on September 9, 2020 and the parties filed responses in November 2020.

HLB filed Case Nos. 20-1494GC and 21-0803G during the period that the Board was requesting and reviewing the jurisdictional challenges raised by FSS. On September 28, 2021, HLB filed an EJR request for Case Nos. 20-1494GC and 21-0803G.

On October 27, 2021, the Board issued separate determinations to deny the EJR requests in all four appeals and to request additional information regarding the issues raised in the appeals to allow the Board to determine whether it has substantive jurisdiction over the matter in the appeals, whether the record is sufficiently developed, whether there are material factual disputes, and whether EJR was an appropriate outcome. , the Board stated that it, "believe[d] that the parties may need at least 3 months to consider the Bo Taking into consideration the complex nature of the dispute, the novel jurisdictional questions raised by that dispute and the extensive amount of analysis and information requested in its RFIs ard's questions before filing a response." Accordingly, the Board directed the parties to confer and jointly propose a briefing schedule.

On November 15, 2021, the parties proposed that the parties would simultaneously file their responses to the RFI on January 7, 2022 and optional responses to the other party's January 7 filing would be due by February 8, 2022. No objections to the Board's RFI were filed at that point.

On November 24, 2012, the Board established January 21, 2022 as the due date for the simultaneous filings and setting March 4, 2022 for the responses, if any, explaining that "[d]ue to the complexity of the issues to be briefed and the intervening holidays, the Board . . . opted to extend by roughly two weeks the briefing time frames proposed by the parties to ensure the parties have sufficient time to research and adequately address the concerns raised in the Board's October 27th letter."

On January 19, 2022, HLB filed an unopposed request to further extend the entire briefing schedule by two weeks for responses to the RFI and stated that the Board's concern about ensuring the parties had sufficient time to adequately address the Board's RFI "have provided prescient."[13] On January 20, 2022, the Board granted the 2-week extension to February 5, 2022 and set March 18, 2022 for the responses, if any.

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[12] Per 42 C.F.R. § 405.1873(e), the Board does not issue final substantive claim findings if the Board issues a jurisdictional dismissal decision or the Board denies EJR.

[13] HLB first referenced all four appeals, Case Nos. 19-0849G, 20-1432G, 20-1494GC and 21-0803G, in its request for extension of time, recognizing that they all deal with the same issues and involve many of the same providers.

The lead Medicare Contractors filed their response to the RFI on February 4, 2022. Further, a day earlier on February 3, 2022, the lead Medicare Contractor in Case No. 20-1432 filed a "Substantive Claim Challenge"[14] against 6 of participants in that case,[15] claiming that these participants failed to either properly claim or self-disallow the Standardized Amount issue in compliance with the substantive claim requirements in 42 C.F.R. § 413.24(j).

On February 5, 2022, HLB filed its response to the RFI and, *for the first time* (3 months after the RFI was issued), included certain objections to the RFI within their response.[16] On March 4, 2022, HLB filed its response to the Substantive Claim Challenge in Case No. 20-1432G, asserting that: (a) 3 of the 5 participants[17] properly protested the Transfer/Discharge Issue on their relevant as-filed Medicare cost reports by including narrative explanations explicitly protesting the Transfer/Discharge Issue and workpapers calculating the estimated underpayment amounts; (b) while the lead Medicare Contractor is correct that the remaining 3 participants[18] failed to properly self-disallow, HLB gave "Board notice that they plan to challenge both the Board's findings and the validity of the Secretary's refabricated self-disallowance requirement generally and as applied here" if the Board were to make adverse findings against any of these 6 participants.[19]

On March 18, 2022, HLB filed a response to the Medicare Contractors' filing on February 4, 2022 regarding the RFI.

Twenty-one days later, on April 8, 2022, the Providers filed a second request for EJR arguing that the Board had the information it requested in the RFI and that because:

> (1) the Board has jurisdiction over this Group Appeal, (2) the group is complete and the Schedule of Providers with jurisdictional documentation has been submitted to the Board and MAC, (3) the Board has all necessary information to decide EJR and there are no disputed factual issues, and (4) the Board lacks the authority to decide the legal issue under appeal because it challenges the validity of final determinations adopted in the FFY 2021 IPPS Final Rule. . . .

On April 25, 2022, the Board issued a Status of Request for Expedited Judicial Review & Notice of Stay of the 30-Day Period. In particular, the Board's letter notified the parties that "the 30-day clock [for the Board to review an EJR request] does not start until ***after*** the Board determines that

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[14] *See supra* note 9 (explaining the Board's use of the term "Substantive Claim Challenge").
[15] The lead Medicare Contractor identified the 5 providers as:
1. Oroville Hospital, Prov. No. 05-0030, FYE 11/30/2019 for the period 10/01/2019 through 11/30/2019;
2. Oroville Hospital, Prov. No. 05-0030, FYE 11/30/2020 for the period 12/01/2019 through 09/30/2020;
3. Berkshire Medical Center, Prov. No. 22-0046, FYE 09/30/2020;
4. Milford Regional Medical Center, Prov. No. 22-0090, FYE 09/30/2020;
5. Good Samaritan Hospital, Prov. No. 05-0471, FYE 09/30/2020; and
6. Elliot Hospital of the City of Manchester, Prov. No. 30-0012, FYE 06/30/2021

[16] *See infra* note 52 (discussing the adverse impact that the delay in making those objections caused).
[17] Berkshire Medical Center, Good Samaritan Hospital, and Elliot Hospital of the City of Manchester.
[18] Oroville Hospital (FYEs 11/30/2019 & 11/30/2020) and Milford Regional Medical Center.
[19] HLB Response to Substantive Claim Challenge, Case No. 20-1432G, at 25 (Mar. 4, 2022).

it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers are participants) underlying an EJR request." In this regard, the Board noted that "there are already ongoing, pending jurisdictional reviews in these group cases"; the jurisdictional questions raised therein are "novel and highly complex"; and "the parties' jurisdictional brief and responsive brief (with supporting documents) are currently under Board review." Finally, the Board confirmed that it would notify the parties "when the jurisdiction and substantive claim review process has been completed and the 30-day period begins."

On May 6, 2022, HLB filed objections to the Board's April 25, 2022 letter's indefinite stay, disputing the status of the group appeals in the Office of Hearings Case and Document Management System ("OH CDMS") and arguing that the Board did not have the authority to stay its determination of the EJR request beyond 30 days from its filing. Significantly, HLB's objections cited only to 42 U.S.C. § 1395oo(f)(1) and did not reference or discuss 42 C.F.R. 405.1842 which implemented that statutory provision or any case law applying those statutory and regulatory provisions.

On May 12, 2022, the lead Medicare Contractor in Case No. 21-0803G filed a Substantive Claim Challenge[20] against 3 participants[21] in that case claiming that these participants failed to either properly claim or self-disallow the Standardized Amount issue in compliance with the substantive claim requirements in 42 C.F.R. § 413.24(j).

On May 16, 2022, the Board issued two communications regarding these group cases. First, the Board denied the Providers' objections to the Board Stay of the 30-day review period, stating that the objections "are incorrect and improperly ignore the Secretary's regulations that otherwise interpret and implement" the EJR provisions in 42 U.S.C. § 1395oo(f)(1). To this end, the Board gave a thorough history of the Secretary's implementation of the EJR provisions in 42 U.S.C. § 1395oo(f)(1) at 42. C.F.R. § 405.1842 and case law applying those statutory and regulatory provisions. The regulation and case law make clear, for good reason, that the 30-day period for the Board to review an EJR request does not begin to run until after the Board finds jurisdiction over the matter in the appeal and notifies the parties that the EJR request is complete. The Board reiterated that 30 days had not yet begun to run since the Board had not yet completed its jurisdictional review and noted that HLB's "Response does not dispute the Board's characterization of the jurisdictional questions raised in this case as 'novel and highly complex' as reflected in the Board's requests for information, the parties' jurisdictional brief and responsive briefs (with supporting documents), and the length of time needed for that briefing (including the Providers' briefing extension request)."

The second May 16, 2022 Board communication was another RFI in the optional groups under Case Nos. 20-1432G and 21-0803G after questions arose during the Board's jurisdictional review of the Schedule of Providers ("SoP") for these cases. The RFI sought certain jurisdictional information regarding the Providers' compliance with the rules and regulations mandating that, in certain situations, commonly owned or controlled providers pursue common issues as part of common issue

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[20] *See supra* note 9.

[21] The lead Medicare Contractor identified the 3 Providers as:

1. Oroville Hospital, Prov. No. 05-0030, FYE 11/30/2020
2. Milford Regional Medical Center, Prov. No. 22-0090, FYE 9/30/2021
3. Elliot Hospital of the City of Manchester, Prov. No. 30-0012, FYE 6/30/2021

related party ("CIRP") groups. The Board confirmed that the RFI affected the 30-day period for responding to the EJR request citing to 42 C.F.R. §§ 405.1842(b), (e)(2)(ii) and (e)(3)(ii).

On June 6, 2022, HLB responded to the Board's RFI, answering the RFI questions and identifying additional noncompliance with the mandatory CIRP group regulations yet requesting that the Board disregard the CIRP requirement that commonly owned or controlled providers appeal a common issue from the same calendar year as members of a CIRP group appeal. Significantly, HLB stated that it could not rule out that "one or more PIH Health hospitals will at some time in the future appeal the Standardized Amount Issue for a portion of FFY 2020."[22] HLB disagreed with the Board's assertion that the 30-day period for Case Nos. 20-1432G and 21-0803G was affected by the Board's RFI because HLB contended that "the issues raised in the Board's May 16, 2022 letter *do not implicate either the Board's jurisdiction over the Group Appeals* or whether the Board has the legal authority to decide the legal issue under appeal, which are the only two criteria for determining whether EJR is appropriate."[23]

On June 6, 2022, HLB also filed a response to the Substantive Claim Challenge in Case No. 21-0803G, asserting that: (a) 2 of the 3 participants[24] properly protested the Transfer/Discharge Issue on their relevant as-filed Medicare cost reports by including narrative explanations explicitly protesting the Transfer/Discharge Issue and workpapers calculating the estimated underpayment amounts; (b) while the lead Medicare Contractor is correct that the remaining participant[25] failed to properly self-disallow, HLB gave "the Board notice that they plan to challenge both the Board's finding and the validity of the Secretary's refabricated self-disallowance requirement in §413.24(j)" if the Board were to make adverse findings against any of the 3 participants.[26]

On June 14, 2022, the Board issued a determination confirming that the Providers' compliance with the mandatory CIRP regulations was not discretionary and *required* that, within 30 days, HLB establish CIRP groups for any CIRP providers in the optional groups appealing the 2020 and 2021 standardized amount issues and then transfer the CIRP providers to those groups. The Board also explained how these pending issues were jurisdictional in nature and continued to affect the commencement of the 30-day EJR review period.[27]

On June 29, 2022, HLB created 3 new CIRP group appeals (which are not covered by this letter), and requested that the Board transfer 3 providers from Case No. 20-1432G and 2 providers from Case No. 21-0803G into those CIRP groups.[28]

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[22] Response to Board's May 16, 2022 Request for Information ("HLB May 16, 2022 Response"), p. 2.
[23] *Id.* pp. 1-2.
[24] Milford Regional Medical Center and Elliot Hospital of the City of Manchester.
[25] Oroville Hospital.
[26] HLB Response to Substantive Claim Challenge, Case No. 21-0803G, at 23 (June 6, 2022).
[27] The Board noted that all of the CIRP issues it raised impact the Board's jurisdiction over the groups and the participants in those groups and cited to 42 C.F.R. § 405.1840(b). Accordingly, the Board concluded that the need to establish a proper group appeal under 42 C.F.R. § 405.1837 is a prerequisite to the substantive review of these appeals and CIRP issues must be resolved prior to the commencement of the 30-day period.
[28] PIH Health FFY 2020 Standardized Amount Base Rate Accuracy CIRP Group, PRRB Case No. 22-1136GC; SolutionHealth FFY 2021 Standardized Amount Base Rate Accuracy CIRP Group, PRRB Case No. 22-1137GC; SolutionHealth FFY 2020 Standardized Amount Base Rate Accuracy CIRP Group, PRRB Case No. 22-1138GC;

The Board acknowledged the creation of the 3 CIRP groups on July 1, 2022 and then granted the 5 transfer requests submitted by HLB on July 8, 2022.[29] In granting the transfer requests, the Board reaffirmed that the 30-day period had not yet begun and the Board continued its jurisdictional review.[30]

Meanwhile, it has come to the Board's attention that, ***before*** the Board could execute the transfers or its jurisdictional review process, HLB ***filed a Complaint*** *in the U.S. District Court for the District of Columbia* ***regarding the merits of their EJR requests*** as filed in these appeals, on July 6, 2022.[31] This filing is significant because 42 C.F.R. § 405.1842(h)(3) specifies that in such instances the Board conduct no further proceedings:

> (h) *Effect of final EJR decisions and lawsuits on further Board proceedings –*
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> ****
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> (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.
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[29] Good Samaritan Hospital (Prov. No. 05-0471) was transferred to Case No. 22-1136GC; Southern New Hampshire Medical Center (Prov. No. 30-0020) and Elliot Hospital (Prov. No. 30-0012) were transferred to Case Nos. 22-1137GC and 22-1138GC.

[30] The July 1, 2022 Board correspondence stated:

> In a June 14, 2022 notification, the Provider Reimbursement Review Board (the "Board") advised the Parties that the 30-day period for the Board to review and issue a determination on a request for expedited judicial review ("EJR") could not begin to run until the common issue related party ("CIRP") issues identified by the Board, and need for the establishment of the proper group appeals under 42 C.F.R. § 405.1837, are resolved. Accordingly, as part of its ongoing jurisdictional review process, the Board notified the Group Representative that it would need to address those participants in the group that were potentially CIRP providers. . . .
>
> Finally, the Board notes that its April 25, 2022 and May 16, 2022 notices remain in effect, namely notice to the parties that the 30-day period to respond to the EJR request has not yet commenced because: (1) the Board has not yet completed its jurisdictional review (in particular as it relates to the Board's substantive jurisdiction over the issue raised in these group appeals and the parties briefing on substantive jurisdiction); and (2) the regulations at 42 C.F.R. §§ 405.1842(a)(4)(ii) and (b)(2) make it 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." Once the Board completes its jurisdictional review, the Board will notify you of its findings (including findings on substantive jurisdiction) and the status of any necessary stay (e.g., notice that the 30-day period has begun).

[31] *The Univ. of Chicago Med. Ctr., et al. v. Becerra*, No. 1:22-cv-01964-TSC (D.D.C. July 6, 2022).

> (iii) *If the lawsuit is filed* ***before a final EJR decision is issued*** on the legal question***, the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[32]

Accordingly, the filing of this Complaint in Federal District Court made clear that the Providers abandoned the Board's jurisdictional review process. Moreover, the Federal Complaint was filed before: (1) the Board had completed HLB's June 29, 2022 request that it transfer certain providers from some of these cases to the appropriate CIRP group cases (that are not included in the above-captioned cases) and (2) the Board had completed its review of substantive jurisdiction, and the associated record development issues, that took the parties roughly five months to brief as a result of their own briefing schedule. This litigation reflects HLB's belief (as stated in its June 6, 2022 filing) that, "the issues raised in the Board's May 16, 2022 letter do not implicate either the Board's jurisdiction over the Group Appeals or whether the Board has the legal authority to decide the legal issue under appeal, which are the only two criteria for determining whether EJR is appropriate."[33] As noted above, the Board's June 14, 2022 letter explained how these CIRP issues were jurisdictional in nature and justified a stay of the commencement of the 30-day EJR review period.

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 group cases.

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

As discussed in more detail above, the Board's correspondence in these cases has notified the parties on multiple occasions, in detail, that, the 30-day period for EJR review does not begin until the Board completes its jurisdictional review and finds jurisdiction. Set forth below is a summary of that explanation.

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

[32] (Emphasis added.)
[33] HLB May 16, 2022 Response. P. 1. (Emphasis in original).

> ***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.[34]

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

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

[34] (Emphasis added).

> **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**.[35]

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."[36] 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

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[35] (Emphasis added).

[36] 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)).

> whether it has jurisdiction and the request for EJR is complete. See 42 C.F.R. § 405.1842.[37]

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.[38]

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). . . .***"[39] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*")[40] 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."[41] 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

---

[37] (Emphasis added.)
[38] Note that the Board's use of the term "stay" (as used in this and prior similar situations) in relation to the 30-day period for responding to the parties' EJR requests, was an inartful use of that term because the Board's intent was to simply notify the parties that the Board had not yet finished its jurisdictional review of the parties' EJR requests and, as such, the 30-day period for the review of the EJR requests had not yet commenced.
[39] 42 U.S.C. § 1395oo(f)(1) (emphasis added).
[40] *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986) (Hereinafter "*Alexandria").*
[41] *Alexandria* at 1244. *See,* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *See also, 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).

> 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***.[42]

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 be 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.[43] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Case and the Board's Jurisdictional Review

HLB filed its lawsuit in federal district court on July 6, 2022 – before the Board had completed its jurisdictional review to confirm whether it had jurisdiction to hear all of the disputes raised in the Providers' April 8, 2022 EJR requests *and* whether the record was sufficiently developed.[44] Having sufficient time to complete the jurisdictional and substantive claim review[45] process is important to ensure that the groups, and all the underlying providers, are properly before the Board both generally and for the issue(s) raised in the EJR requests. 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 complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise.

As stated above, 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."

Specifically, absent a proper jurisdictional review, there is a risk of prohibited participation of CIRP providers in optional groups. Because the creation of new CIRP groups, and the Board's grant of the transfer requests of the relevant providers into those CIRP groups, *occurred* ***after*** *the Federal complaint was filed*, 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).

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[42] *Alexandria Hosp. v. Bowen*, 631 F. Supp. at 1244.
[43] 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.
[44] The complexity of the Providers' claims, leading to the need for a robust and complete record, is reflected in the nature of the questions raised in the Board's October 27, 2022 RFI.
[45] *See supra* note 9 (explaining the Board's use of the term "Substantive Claim Challenge").

As a result of this timing, there are significant questions in which case (or cases) Good Samaritan Hospital, Elliot Hospital, and Southern New Hampshire Medical Center area are participating. For example, it is unclear whether the Board's July 8, 2022 grant of the transfer of Good Samaritan Hospital from Case No. 20-1432G to Case No. 22-1136GC is void due to the prohibition in § 405.1842(h)(3)(iii) on further Board proceedings once a lawsuit is filed.[46]

HLB has made clear in its various filings, that it disagrees with the Board's interpretation of the jurisdictional requirements required in EJR proceedings and the need to resolve any jurisdictional and substantive challenges before ruling on an EJR request. Accordingly, its lawsuit would appear to be based on a contention that the Board failed to process its EJR requests in the 30-day period prescribed in 42 U.S.C. § 1395oo(f)(1). Significantly, the Board consistently notified the parties that the 30-day period had not begun because the Board had not completed its jurisdictional review. However, *at no point in the proceedings before the Board* has HLB referenced ***or*** challenged the Board's stated reliance on 42 C.F.R. § 405.1842(b)(2) in issuing that notification or otherwise challenged the validity of that regulation. Thus, through that litigation, it is clear that HLB has abandoned the Board's jurisdictional review process and appears to be challenging the Secretary's implementation at 42 C.F.R. §§ 405.1842(a)(4)(ii) and 405.1842(b)(2) of 30-day period prescribed in § 1395oo(f)(1) and the Board's notice to the parties of its reliance on of those regulations. The jurisdictional review process included the compliance of the participants in these groups with the mandatory CIRP group regulations. This is basic jurisdiction because, as noted in 42 C.F.R. §§ 405.1837(a) and 405.1837(b)(1) (which implement 42 U.S.C. § 1395oo(f)(1)[47]), a commonly owned or controlled provider must comply with those regulations in order to have a right to a hearing as part of a group.

HLB filed a lawsuit in federal district court on July 6, 2022, ***without notifying the Board*** *or the opposing party* of its intent to file the Complaint or the initiation of federal litigation. This is in direct violation of Board Rule 1.3 (Nov. 2021) which specifies: "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."

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[46] In filings made in Case Nos. 20-1432G and 21-0803G, HLB asserted that, ". . . questions concerning whether providers are properly included in optional group appeals are not grounds for delaying the statutory 30-day deadline in 42 U.S.C. §1395(f)(1) for deciding. . ." a hospitals' EJR request. This suggests that HLB does not believe that abandoned the Board's jurisdictional review process as it relates to CIRP issues. However, the Board responded and reaffirmed that compliance with the mandatory CIRP rules are jurisdictional questions related to a provider's right to hearing, namely whether the provider must exercise that right as part of a CIRP group versus and individual appeal or optional group appeal. HLB's disregard for the Board's jurisdiction review requirements by filing the Federal Complaint is especially damning considering that HLB admitted that it could not "rule out the possibility that one or more PIH Health hospitals. . ." would file an appeal of the Standardized Amount Issue for a portion of FFY 2020.

[47] 42 U.S.C. § 1395oo(f)(1) states: "Any appeal to the Board or action for judicial review by providers which are under common ownership or control or which have obtained a hearing under subsection (b) must be brought by such providers as a group with respect to any matter involving an issue common to such providers."

*The Board **admonishes** HLB for blatantly ignoring Board Rule 1.3 through its failure to communicate with the Board and the opposing party of the litigation it filed and its intention to abandon the Board's ongoing proceedings*, which included:

1. The Board's ongoing review of the substantive jurisdiction examining review of substantive jurisdiction examining, in part, whether 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the FFY 1984 standardized amount**s**[48] for IPPS as adopted in the interim final rule published on September 1, 1983[49] because the FFY 1984 standardized amount**s** are (from a backward-looking perspective) inextricably tied to[50] an unreviewable agency action, namely the FFY 1984 and 1985 budget neutrality adjustments at 42 U.S.C. § 1395ww(e)(1)(B) which are a "proportional adjustment in *applicable percentage increase*"[51] and are precluded from administrative and judicial review pursuant to § 1395ww(d)(7)(A).[52]

2. The Board's findings on the sufficiency of the record in this case as well as whether there were any factual disputes.[53] The Board notified the parties of this ongoing review and confirmed that, once the Board completed that review, it would notify the parties of its jurisdictional findings and the status of any necessary stay (*e.g.*, notice that the 30-day period has begun).

3. The Board's decision to grant the 5 transfer requests in Case Nos. 20-1432G and 21-0803G on July 8, 2022 without knowing that 2 days earlier the Providers had filed its Complaint in federal district court.

4. Finally, if the Board were to find jurisdiction and issue an EJR decision, the Board's findings on the Substantive Claim Challenges[54] regarding 413.24(j) compliance filed in Case Nos. 20-1432G regarding 6 participants (3 of which require resolution of factual

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[48] As discussed more fully at *supra* note 1, when IPPS was implemented, the statute required multiple standardized amounts and now there is just one equalized rate.
[49] 48 Fed. Reg. 39752, 39838 (Sept. 1, 1983).
[50] *See supra* note 7 (citing *Florida Health Sciences Center, Inc v. Sec'y of Health & Human Servs*., 830 F.3d 515, 521 (D.C. Cir. 2016)).
[51] 42 U.S.C. § 1395ww(e)(emphasis added). Section 1395ww(e) is entitled "Proportional adjustment in *applicable percentage increases*." (Emphasis added.) The FFY 1984 and 1985 budget neutrality adjustments in § 1395ww(e)(1)(B) were made to ensure that aggregate payments for those years under IPPS "are not greater ***or*** less than" what would have been paid without IPPS. 42 U.S.C. § 1395ww(e)(1)(B)(emphasis added). Moreover, the FFY 1984 and 1985 budget neutrality adjustments would appear to serve as the "applicable percentage increase" for FFY 1984 and 1985 since no "applicable percentage increase" is provided for those years in 42 U.S.C. § 1395ww(b)(3)(B) as cross referenced in §§ 1395ww(d)(2)(B)(ii) for FFY 1984 and 1395ww(d)(3(A) for FFY 1985 and forward. In this regard, the "applicable percentage increase" ***as used in § 1395ww(d)*** is defined at § 1395ww(b)(3)(B)(i) *but only for FFYs 198**6** forward*.
[52] HLB's objections to the Boar's October 27, 2021 RFI were not filed ***until over 3 months late***r as part of its February 5, 2022 response. *The delay in making those objections **deprived the Board** of an opportunity to modify or clarify the RFI, as appropriate*. The Board's findings on jurisdiction would include a response to those delayed objections.
[53] The novel and highly complex nature of these issues is reflected in the roughly 5 month briefing schedule, that the parties themselves chose, to respond to the Board's October 27, 2022 questions on these issues.
[54] *See supra* note 9.

disputes[55]) and in Case No. 21-0803G regarding 3 participants (2 of which require resolution of factual disputes[56]).

The regulation at 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings. The Providers are pursuing the merits of their appealed issue in the District Court for the District of Columbia, and there are no remaining issues beyond that covered by the EJR requests.[57] Accordingly, consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1[58] the Board takes the following actions:

1. Closes these 4 group cases and removes them from the Board's docket; and

2. Suspends completion of its jurisdictional and substantive claim review processes.

The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. 405.1877(g)(2).

Board Members Participating:

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

For the Board:

8/9/2022

X Clayton J. Nix

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

cc: Pamela VanArsdale, NGS
Lorraine Frewert, Noridian Healthcare Solutions c/o Cahaba Safeguard Administrators
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[55] HLB's March 4, 2022 response to the Substantive Claim Challenge filed in Case No. 20-1432G: (1) disputed the lead Medicare Contractor's claim that Berkshire Medical Center, Good Samaritan Hospital, and Elliot Hospital of the City of Manchester failed to properly self-disallow; and (2) included certain additional documentation in support of their position.
[56] HLB's June 6, 2022 response to the Substantive Claim Challenged filed in Case No. 21-0803G: (1) disputed the lead Medicare Contractor's claim that Oroville Hospital and Milford Regional Medical Center failed to properly self-disallow; and (2) included certain additional documentation in support of their position.
[57] The Board notes that, *in order for the Board to have jurisdiction over a group*, the group may only contain one legal issue per 42 C.F.R. § 405.1837(a) and, as such, there should be no other issues outside of the EJR request.
[58] *See supra* note 4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Russell Jenkins
Hospital Reimbursement Group
5123 Virginia Way, Suite A-12
Brentwood, TN 37027

Bernard M. Talbert, Esq.
Federal Specialized Services
1701 S. Racing Avenue
Chicago, IL 60608-4058

RE: ***Closure of Cases & Suspension of Jurisdictional Review Process***
Standardized Amount Base Rate Accuracy Groups for OSF FFYs 2019, 2021
Case Nos. 19-0710GC, 21-1142GC

Dear Messrs. Jenkins and Talbert:

As the parties are aware, Hospital Reimbursement Group ("HRG"), the Providers' designated representative, filed a *consolidated* request for expedited judicial review ("EJR") with the Provider Reimbursement Review Board ("Board") on April 8, 2022 for the above-referenced group cases in connection with the following allegation regarding the standardized amount[1] *as used* ***in the payment rates*** *for inpatient prospective payment system ("IPPS")* ***during*** *federal fiscal years ("FFY") 2019 and 2021*:

> CMS's treatment of transfers as discharges for the purpose of rate-setting in FFY 1984 caused an understatement of its "average cost per discharge" calculation and the resulting FFY 1984 standardized amounts, which led to IPPS underpayments from FFY 1984 to this day because the standardized amounts in each FFY are based on the standardized amounts from the prior FFY ***with certain percentage adjustments***.[2]

It has come to the Board's attention that the Providers have filed a complaint in federal district court[3] to pursue the merits of their *consolidated* EJR request, notwithstanding the fact that the Board has not yet completed its jurisdictional review and not yet issued a determination on the EJR request. As set forth in more detail below, the Board hereby takes the following actions consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1[4]:

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[1] 42 U.S.C. §§ 1395ww(d)(2)(D) and (d)(3) required that the Secretary compute two average standardized amounts for discharges occurring during a fiscal year—one for hospitals in large urban areas and another for hospitals in other areas. However, beginning for discharges on after April 1, 2003 those standardized amounts were equalized to arrive at one rate. *See* 69 Fed. Reg. 48916, 49077-78 (Aug. 11, 2004). This change was effectuated through a series of legislation, namely Consolidated Appropriations Resolution, 2003, Pub. Law 108-7, § 402(b), 117 Stat. 11, 548 (2003); Pub. Law 108-89, § 402, 117 Stat. 1131, 1134-36 (2003) (includes provision for certain preclusion of administrative or judicial review); Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. Law 108-173, § 401, 117 Stat. 2066, 2262-64 (2003).

[2] Second EJR Request at 4 (Apr. 8, 2022) (citations omitted).

[3] *See infra* note 11.

[4] 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.

1. Close these 2 CIRP group appeals; and

2. Suspend completion of the ongoing jurisdictional review process, including but not limited to, the Board-initiated review of substantive jurisdiction examining, in part, whether 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the FFY 1984 standardized amount**s**[5] for IPPS as adopted in the interim final rule published on September 1, 1983[6] because the FFY 1984 standardized amount**s** are (from a backward-looking perspective) inextricably tied to[7] an unreviewable agency action, namely the FFY 1984 and 1985 budget neutrality adjustments at 42 U.S.C. § 1395ww(e)(1)(B) which are a "proportional adjustment in *applicable percentage increase*"[8] and are precluded from administrative and judicial review pursuant to § 1395ww(d)(7)(A).

Procedural Background:

HRG initially filed an EJR request for Case No. 19-0710G on August 10, 2020. Federal Specialized Services ("FSS") filed a response to the EJR request on August 25, 2020. In reviewing the EJR request, the Board determined that it needed additional information with respect to jurisdiction and, as a result, issued a Request for Information ("RFI") on September 9, 2020 and the parties filed responses on October 9, 2020 and November 6, 2020.

HRG filed Case No. 21-1142GC during the period that the Board was requesting additional information and reviewing jurisdiction. On September 28, 2021, HRG filed an EJR request for Case No. 21-1142GC.

On October 27, 2021, the Board issued separate determinations to deny the EJR requests in both appeals and to request additional information regarding the issues raised in the appeals to allow the Board to determine whether it has substantive jurisdiction over the matter in the appeals, whether the record is sufficiently developed, whether there are material factual disputes, and whether EJR

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[5] As discussed more fully at *supra* note 1, when IPPS was implemented, the statute required multiple standardized amounts and now there is just one equalized standardized amount.

[6] 48 Fed. Reg. 39752, 39838 (Sept. 1, 1983).

[7] *See Florida Health Sciences Center, Inc v. Sec'y of Health & Human Servs*., 830 F.3d 515, 521 (D.C. Cir. 2016) (citing to Texas Alliance for Home Care Servs. v. Sebelius, 681 F.3d 402 (D.C. Cir. 2012) (stating "The critical factor in *Texas Alliance* was not whether the statute barred from review the agency's ultimate determination or merely an intermediate step in reaching that decision. Rather, we were concerned with the close connection between the element being challenged and the decision that could not be challenged in court. *Texas Alliance*, 681 F.3d at 409–11. That analysis applies with equal force here. The dispositive issue is whether the challenged data are inextricably intertwined with an action that all agree *is* shielded from review, regardless of where that action lies in the agency's decision tree. Because the data here are inextricably intertwined with the Secretary's estimate of uncompensated care, Tampa General cannot challenge the Secretary's choice of data in court.").

[8] 42 U.S.C. § 1395ww(e)(emphasis added). Section 1395ww(e) is entitled "Proportional adjustment in *applicable percentage increases*." (Emphasis added.) The FFY 1984 and 1985 budget neutrality adjustments in § 1395ww(e)(1)(B) were made ***to the standardized amount**s* to ensure that aggregate payments for those years under IPPS "are not greater ***or*** less than" what would have been paid without IPPS. 42 U.S.C. § 1395ww(e)(1)(B)(emphasis added). Moreover, the FFY 1984 and 1985 budget neutrality adjustments would appear to serve as the "applicable percentage increase" for FFY 1984 and 1985 since no "applicable percentage increase" is provided for those years in 42 U.S.C. § 1395ww(b)(3)(B) as cross referenced in §§ 1395ww(d)(2)(B)(ii) for FFY 1984 and 1395ww(d)(3(A) for FFY 1985 and forward. In this regard, the "applicable percentage increase" ***as used in § 1395ww(d)*** is defined at § 1395ww(b)(3)(B)(i) *but only for FFYs 198**6** forward*.

was an appropriate outcome. Taking into consideration the complex nature of the dispute, the novel jurisdictional questions raised by that dispute and the extensive amount of analysis and information requested in its RFIs, the Board stated that it, "believe[d] that the parties may need at least 3 months to consider the Board's questions before filing a response." Accordingly, the Board directed the parties to confer and jointly propose a briefing schedule.

On November 16, 2021, the parties proposed that the parties would simultaneously file their responses to the Board's RFI on January 7, 2022 and optional responses to the other party's January 7 filing would be due by February 8, 2022. No objections to the Board's RFI were filed at that point.

On November 24, 2022, the Board established January 21, 2022 as the due date for the simultaneous filings and set March 4, 2022 for the responses, if any, explaining that "[d]ue to the complexity of the issues to be briefed and the intervening holidays, the Board . . . opted to extend by roughly two weeks the briefing time frames proposed by the parties to ensure the parties have sufficient time to research and adequately address the concerns raised in the Board's October 27th letter."

On January 19, 2022, HRG filed an unopposed request for a two-week extension to the entire briefing schedule for responses to the RFI and stated that the Board's concern about ensuring the parties had sufficient time to adequately address the Board's RFI "have proved prescient."[9] On January 21, 2022, the Board granted the 2-week extension to February 5, 2022 and set March 18, 2022 for the responses, if any.

On February 4, 2022, the lead Medicare Contractors filed their response to the RFI. Similarly, on February 5, 2022, HRG filed its response to the RFI but, *for the first time* (over 3 months after the RFI was issued), included certain objections to the RFI within their response.[10] On March 18, 2022, HRG filed a response to the Medicare Contractors' filing.

Twenty-one days later, on April 8, 2022, the Providers filed a second request for EJR arguing that the Board had the information it requested in the RFI and that because:

> (1) the Board has jurisdiction over this Group Appeal, (2) the group is complete and the Schedule of Providers with jurisdictional documentation has been submitted to the Board and MAC, (3) the Board has all necessary information to decide EJR and there are no disputed factual issues, and (4) the Board lacks the authority to decide the legal issue under appeal because it challenges the validity of final determinations adopted in the FFY 2021 IPPS Final Rule. . . .

On April 25, 2022, the Board issued a Status of Request for Expedited Judicial Review & Notice of Stay of the 30-Day Period. In particular, the Board's letter notified the parties that "the 30-day clock [for the Board to review an EJR request] does not start until ***after*** the Board determines that

[9] HRG filed two separate requests for these appeals on the same date. The extension request for Case No. 19-0710GC also included 5 other groups: 19-1723GC, 19-1735GC, 19-1763GC, 19-0233GC, and 19-1628GC, however a second EJR request was not filed in these other 5 groups. The extension request for Case No. 21-1142GC only addressed that one appeal.

[10] *See infra* note 29 (discussing the adverse impact that the delay in making those objections caused).

it has jurisdiction over the relevant providers (*as well as* any associated group(s) in which these providers are participants) underlying an EJR request." In this regard, the Board noted that "there are already ongoing, pending jurisdictional reviews in these group cases"; the jurisdictional questions raised therein are "novel and highly complex"; and "the parties' jurisdictional brief and responsive brief (with supporting documents) are currently under Board review." Finally, the Board confirmed that it would notify the parties "when the jurisdiction and substantive claim review process has been completed and the 30-day period begins."

On May 6, 2022, HRG filed objections to the Board's April 25, 2022 letter's indefinite stay, disputing the status of the group appeals in the Office of Hearings Case and Document Management System ("OH CDMS") and arguing that the Board did not have the authority to stay its determination of the EJR request beyond 30 days from its filing. Significantly, HRG's objections cited only to 42 U.S.C. § 1395oo(f)(1) and did not reference or discuss 42 C.F.R. § 405.1842 which implemented that statutory provision or any case law applying those statutory and regulatory provisions.

On May 26, 2022, the Board denied the Providers' objections to the Board Stay of the 30-day review period, stating that the objections "are incorrect and improperly ignore the Secretary's regulations that otherwise interpret and implement" the EJR provisions in 42 U.S.C. § 1395oo(f)(1). To this end, the Board gave a thorough history of the Secretary's implementation of the EJR provisions in 42 U.S.C. § 1395oo(f)(1) at 42. C.F.R. § 405.1842 and case law applying those statutory and regulatory provisions. The regulation and case law make clear, for good reason, that the 30-day period for the Board to review an EJR request does not begin to run until after the Board finds jurisdiction over the matter in the appeal and notifies the parties that the EJR request is complete. The Board reiterated that 30 days had not yet begun to run since the Board had not yet completed its jurisdictional review and noted that HRG's "Response does not dispute the Board's characterization of the jurisdictional questions raised in this case as 'novel and highly complex' as reflected in the Board's requests for information, the parties' jurisdictional brief and responsive briefs (with supporting documents), and the length of time needed for that briefing (including the Providers' briefing extension request)."

Meanwhile, it has come to the Board's attention that, even though the jurisdictional review process had not yet been completed, HRG ***filed a Complaint*** *in the U.S. District Court for the District of Columbia* ***regarding the merits of their EJR requests*** as filed in these appeals, on July 6, 2022.[11] This filing is significant because 42 C.F.R. § 405.1842(h)(3) specifies that in such instances the Board conduct no further proceedings:

> (h) *Effect of final EJR decisions and lawsuits on further 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

[11] *Saint Francis Med. Ctr., et al. v. Becerra*, No. 1:22-cv-01960-RCL (D.D.C. July 6, 2022).

> 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.
>
> ****
>
> (iii) *If the lawsuit is filed* ***before a final EJR decision is issued*** on the legal question, ***the Board may not conduct any further proceedings*** on the legal question or the matter at issue until the lawsuit is resolved.[12]

Accordingly, the filing of this Complaint in Federal District Court made clear that the Providers abandoned the Board's jurisdictional review process. In particular, the Complaint was filed before the Board had completed its review of substantive jurisdiction, and the associated record development issues, that took the parties roughly five months to brief as a result of their own briefing schedule.

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 group cases.

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

As discussed in more detail above, the Board's correspondence in these cases has notified the parties on multiple occasions, in detail, that, the 30-day period for EJR review does not begin until the Board completes its jurisdictional review and finds jurisdiction. Set forth below is a summary of that explanation.

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

[12] (Emphasis added.)

> 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.[13]

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

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

[13] (Emphasis added).

> (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**.[14]

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."[15] 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.[16]

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[14] (Emphasis added).

[15] 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)).

[16] (Emphasis added.)

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.[17]

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). . . .***"[18] Thus, as the Court in *Alexandria Hospital v. Bowen* ("*Alexandria*")[19] 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."[20] 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***.[21]

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

[18] 42 U.S.C. § 1395oo(f)(1) (emphasis added).

[19] *Alexandria Hosp. v. Bowen*, 631 F. Supp. 1237, 1244 (W.D. Va. 1986) (Hereinafter "*Alexandria").*

[20] *Alexandria* at 1244. *See,* H.R. Rep. No. 96–1167, *reprinted in* 1980 U.S. Code Cong. & Ad. News at 5757; *See also, 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).

[21] *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 be 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.[22] Not only are the federal trial courts ill-suited for making such determinations, it is a task assigned to the Board, *by statute*.

The above discussion makes it clear that, per the regulations at 42 C.F.R. §§ 405.1837(a)(4)(ii) and 405.1837(b)(2), the 30-day EJR review period, specified at 42 U.S.C. § 1395oo(f)(1), does not begin until the Board completes its jurisdictional review process and finds jurisdiction.

B. Status of the Case and the Board's Jurisdictional Review

HRG filed its lawsuit in federal district court on July 6, 2022 – before the Board had completed its jurisdictional review to confirm whether it had jurisdiction to hear all of the disputes raised in the Providers' April 8, 2022 *consolidated* EJR request *and* whether the record was sufficiently developed.[23] Having sufficient time to complete the jurisdictional and substantive claim review[24] process is important to ensure that the groups, and all 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 complied with the mandatory CIRP group rules). Without a proper jurisdictional review, fraud, waste and abuse concerns could arise.

As stated above, 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."
HRG has made clear in its various filings, that it disagrees with the Board's interpretation of the jurisdictional requirements required in EJR proceedings and the need to resolve any jurisdictional challenges before ruling on an EJR request. Accordingly, its lawsuit would appear to be based on a contention that the Board failed to process its EJR request in the 30-day period prescribed in 42 U.S.C. § 1395oo(f)(1). Significantly, the Board consistently notified the parties that the 30-day period had not begun because the Board had not completed its jurisdictional review. However, *at no point in the proceedings before the Board* has HRG referenced ***or*** challenged the Board's stated reliance on 42 C.F.R. § 405.1842(b)(2) in issuing that notification or otherwise challenged the validity of that regulation. Thus, through that litigation, it is clear that HRG has abandoned the Board's jurisdictional review process and appears to be challenging the Secretary's implementation

[22] 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.
[23] The complexity of the Providers' claims, leading to the need for a robust and complete record, is reflected in the nature of the questions raised in the Board's October 27, 2022 RFI.
[24] 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."

at 42 C.F.R. §§ 405.1842(a)(4)(ii) and 405.1842(b)(2) of 30-day period prescribed in § 1395oo(f)(1) and the Board's notice to the parties of its reliance on of those regulations.

HRG filed a lawsuit in federal district court on July 6, 2022, ***without notifying the Board*** *or the opposing party* of its intent to file the Complaint or the initiation of federal litigation. This is in direct violation of Board Rule 1.3 (Nov. 2021) which specifies: "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."

The Board ***admonishes*** *HRG for blatantly ignoring Board Rule 1.3 through its failure to communicate with the Board and the opposing party of the litigation it filed and its intention to abandon the Board's ongoing proceedings*, which included:

1. The Board's ongoing review of the substantive jurisdiction examining review of substantive jurisdiction examining, in part, whether 42 U.S.C. § 1395ww(d)(7)(A) precludes administrative and judicial review of the FFY 1984 standardized amount***s***[25] for IPPS as adopted in the interim final rule published on September 1, 1983[26] because the FFY 1984 standardized amount***s*** are (from a backward-looking perspective) inextricably tied to[27] an unreviewable agency action, namely the FFY 1984 and 1985 budget neutrality adjustments at 42 U.S.C. § 1395ww(e)(1)(B) which are a "proportional adjustment in *applicable percentage increase*"[28] and are precluded from administrative and judicial review pursuant to § 1395ww(d)(7)(A).[29]

2. The Board's findings on the sufficiency of the record in this case as well as whether there were any factual disputes.[30] The Board notified the parties of this ongoing review and confirmed that, once the Board completed that review, it would notify the parties of its jurisdictional findings and the status of any necessary stay (*e.g.*, notice that the 30-day period has begun).

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[25] As discussed more fully at *supra* note 1, when IPPS was implemented, the statute required multiple standardized amounts and now there is just one equalized rate.
[26] 48 Fed. Reg. 39752, 39838 (Sept. 1, 1983).
[27] *See supra* note 7 (citing to *Florida Health Sciences Center, Inc v. Sec'y of Health & Human Servs*., 830 F.3d 515, 521 (D.C. Cir. 2016).
[28] 42 U.S.C. § 1395ww(e)(emphasis added) (Entitled "Proportional adjustment in *applicable percentage increases*."). The FFY 1984 and 1985 budget neutrality adjustments in § 1395ww(e)(1)(B) were made ***to the standardized amount***s to ensure that aggregate payments for those years under IPPS "are not greater ***or*** less than" what would have been paid without IPPS. 42 U.S.C. § 1395ww(e)(1)(B)(emphasis added). Moreover, the FFY 1984 and 1985 budget neutrality adjustments would appear to serve as the "applicable percentage increase" for FFY 1984 and 1985 since no "applicable percentage increase" is provided for those years in 42 U.S.C. § 1395ww(b)(3)(B) as cross referenced in §§ 1395ww(d)(2)(B)(ii) for FFY 1984 and 1395ww(d)(3(A) for FFY 1985 and forward. In this regard, the "applicable percentage increase" ***as used in § 1395ww(d)*** is defined at § 1395ww(b)(3)(B)(i) *but only for FFYs 198**6** forward*.
[29] HRG's objections to the Board's October 27, 2021 RFI were not filed ***until over 3 months later*** as part of its February 5, 2022 response. *The delay in making those objections* ***deprived the Board*** *of an opportunity to modify or clarify the RFI, as appropriate*. The Board's findings on jurisdiction would include a response to those delayed objections.
[30] The novel and highly complex nature of these issues is reflected in the roughly 5 month briefing schedule, that the parties themselves chose, to respond to the Board's October 27, 2022 questions on these issues.

The regulation at 42 C.F.R. § 405.1842(h)(iii) bars the Board from conducting any further proceedings. The Providers are pursuing the merits of their appealed issue in the District Court for the District of Columbia, and there are no remaining issues beyond the EJR request.[31] Accordingly, consistent with 42 C.F.R. § 405.1842(h)(3)(iii) and Federal Rule of Civil Procedure 62.1[32] the Board takes the following actions:

1. Close these 2 CIRP group appeals and remove them from the Board's docket; and

2. Suspend completion of its jurisdictional review process.

The Board will conduct no further proceedings in these appeals absent a remand from the Administrator, pursuant to 42 C.F.R. § 405.1877(g)(2).

Board Members Participating:

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

For the Board:

8/9/2022

X Clayton J. Nix

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

cc: Byron Lamprecht, WPS Government Health Administrators
Wilson Leong, FSS
Jacqueline Vaughn, OAA

[31] The Board notes that, *in order for the Board to have jurisdiction over a group*, the group may only contain one legal issue per 42 C.F.R. § 405.1837(a) and, as such, there should be no other issues outside of the EJR request.
[32] *See supra* note 4.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
Southwest Consulting SEH 2011 DSH SSI Fraction Part C Days CIRP Group
Case No. 14-3870GC

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) filed in the above-referenced case on June 30, 2022.[1] Significantly, the EJR request represents that the above-referenced case was remanded (among others) to the Board by the Administrator's Remand Order dated June 3, 2022 and included a copy of that Order as Exhibit 1. Set forth below is the Board's determination to deny the EJR request as improper and void**,** in the first instance, since the Administrator's Remand referenced in the EJR request did ***not*** apply to this case and the Board has not reopened this case.

In re: Allina II-Type DSH Adjustment Cases and the Administrator's Remand and Order

The above-referenced common issue related party ("CIRP") group appeal[2] includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

In 2017 and 2018, the Providers in a number of related cases filed complaints in the D.C. District Court challenging the Board's dismissal of their respective cases for lack of jurisdiction over the Part C issue.[3] In April 2018, the agency issued CMS Ruling 1727-R announcing that the agency would acquiesce in the *Banner* decision, and apply the Court's holding in future cases. The Court consolidated the Providers' court actions into the following consolidated matter: *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C). On December 2, 2021, the Providers, among other hospitals, and the Secretary, submitted a joint status report requesting

[1] The EJR request covered six appeals. The Board's determination as to the other five appeals will be issued under separate cover.
[2] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[3] *Id.*; *See Adcare Hospital et al. v. Becerra*, 17-cv-1896 (D.D.C.); *St. Mary's Health Care System et al. v. Becerra*, 17-cv-2106 (D.D.C.).

that the D.C. District Court vacate these Board jurisdictional dismissals made under the 2008 self-disallowance regulation and remand their cases to the Secretary. Four days later, the Court issued an order granting that request.

On June 3, 2022, the CMS Administrator issued a Remand Order responding to the Court's Order.[4] The Administrator remanded specific providers and appeals back to the Board and ordered that the Board revisit them in light of the Court's December 6, 2021 Order and the *Banner* decision. The Administrator's remand specifically listed 31 Board cases on a list enclosed as Attachment A and that list does ***not*** include Case No. 14-3870GC.[5]

Board's Decision

As Case No. 14-3870GC was not included within the Administrator's Remand Order and has not been reopened by the Board (pursuant to that Order or otherwise), the Board finds that this case remains in a closed status and the EJR requests challenging the validity of the Part C Days policy adopted in the FY 2005 IPPS final rule, the CMS Ruling 1739-R, and the June 3, 2022 Administrator's Remand Order were improper and void in the first instance. Accordingly, the Board hereby **denies** Providers' EJR Request as improper and void in the first instance.

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:

8/12/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Judith Cummings, CGS Administrators
Jacqueline Vaughn, CMS OAA

[4] CMS Administrator's Order (Jun. 3, 2022).
[5] The sister case under Case No. 14-3869GC entitled "Southwest Consulting SEH 2011 DSH Medicaid Fraction Part C Days CIRP Group" for St. Elizabeth Medical Center, Prov. No. 18-0035, FYE 12/31/2011 was included in the remand order and was reopened.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert L. Roth, Esq.
Hooper, Lundy and Bookman
401 9th Street, NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
21-0884GC Care New England FFY 2021 Area Wage Index Standardized Amt. Reduction CIRP
21-0885GC Emory Healthcare FFY 2021 Area Wage Index Standardized Amt. Reduction CIRP
21-0886GC Yale-New Haven FFY 2021 Area Wage Index Standardized Amt. Reduction CIRP
21-0887GC Univ. of Chicago MC FFY 2021 Area Wage Index Stand. Amt. Reduction CIRP
21-0888GC UNC Health FFY 2021 Area Wage Index Standardized Amt. Reduction CIRP Grp.
21-0918GC HCA FFY 2021 Area Wage Index Standardized Amount Reduction CIRP Group
21-0920G Hooper Lundy & Bookman FFY 2021 Area Wage Index Stand. Amt. Reduction

Dear Mr. Roth:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' *consolidated* request for expedited judicial review ("EJR") filed on July 15, 2022 in the above-referenced 7 group appeals. On July 21, 2022, Federal Specialized Services ("FSS") filed a *consolidated* response noting that there were substantive claim issues because a "*substantive claim challenge*[1] determination cannot be made as cost reports have "***not*** been filed for the groups."[2] Based on this fact and the fact that the Providers had not yet filed their position paper that allegedly "could inform their substantive claim challenge review," FSS requested "an extension to finalize its substantive claim challenge and jurisdictional review." Significantly, the request *failed* to state how much additional time was needed for either review and to brief the challenges. On August 2, 2022, the Providers filed its opposition to FSS' extension request.

The Board has considered FSS' request and the Providers' opposition thereto, and **denies** FSS' request for an *unspecified* amount of additional time to respond to the EJR request. Here, the Providers EJR request is based on a challenge to a Final Rule published in the Federal Register, thereby simplifying any potential jurisdictional issues. In this regard, cost reports are not required to be filed in order for the Board to have jurisdiction over this appeal pursuant to 42 U.S.C. § 1395oo(a).[3] Further, in this case, all of the Providers in these group appeals were direct adds, and were ***timely*** added on the same date as the initial group appeal requests. Indeed, it is clear from the OH CDMS system-generated Schedules of Providers (attached to this letter) that

[1] As explained 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" ***as required*** *by 42 C.F.R. § 413.24(j).*
[2] (Emphasis added.)
[3] *See Washington Hospital Center v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).

these appeals are timely, and the minimum amount in controversy requirement for a group appeal has been met in each of the group cases. Finally, relative to jurisdiction, FSS has not pointed to any specific jurisdictional concern that needs further development (*e.g.*, a CIRP provider inappropriately participating in an optional group, preclusion of administrative or judicial review of the matter at issue).

This leaves the additional time requested to complete its review of potential substantive claim challenges.[4] However, in making its extension request, FSS failed to articulate either the amount of time needed to brief its position or a persuasive reason as to *why* they needed more time to review the cases for potential "Substantive Claim Challenges."[5] In this regard, FSS contends that the appeals are based on an appeal of Federal Registers and, as a result, the cost reports have not been filed and FSS needed more time to make a substantive claim determination for that reason. However, any challenge based that reason is a ***generic*** argument and does *not* require participant-specific information or review. Moreover, as discussed more fully below, the Board finds that a substantive claim determination is not yet ripe in these cases in those instances where the appeal is filed based on a Federal Register appeal and no cost report has yet been filed (*i.e.*, not been filed as late at the Medicare Contractor's review of the EJR request). Finally, it is unclear how the Providers' position paper would have facilitated review of compliance with § 413.24(j), particularly since the requirements in Board Rule 7.3.3 to submit documentation on self-disallowances only apply to the appeal requests being filed to establish a case. For these reasons, the Board denies FSS' request for an extension of time, and proceeds with an EJR determination.[6]

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[4] The Board notes that the FSS' extension request also did not meet the following self-effectuation extension provided in Board Rule 44.6 as FSS did not include such a certification:

> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either: . . . .
>
> 2. Submit a filing wherein the Medicare contractor certifies that it will, in fact, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).

Indeed, FSS did not file in any of the group cases the generic substantive claim challenge briefing it promised.

[5] *See supra* note 2 (defining term "Substantive Claim Challenge").

[6] The Board recognizes that the lead Medicare Contractor in Case No. 21-0887GC later filed a Substantive Claim Challenge on August 3, 2022 (19 days after the request for EJR was filed). However, this Challenge was filed only in that case and was specific to the 2 participants in that case and contained no reference to (much less any explanation of how it related to) the extension request. Though not explicitly stated, it appears that, subsequent to filing the group appeal, the 2 participants filed their as-filed cost reports because the Medicare Contractor is asserting that each participant submitted a summary of protested amounts with the as-filed cost report but the Area Wage Index issue was not listed in the summary and "there is nothing in the record demonstrating that the Provider properly established a self-disallowed item for the specific issue on appeal in accordance with Medicare Policy." The FSS extension request was scant on details and only represented that "cost reports have not been filed for the groups" (and, in contrast did ***not*** state FSS needed time to confirm whether each of the participants had filed their cost report since the appeal was filed). Further, FSS only gave one reason it needed additional time, namely additional time to develop the following *generic* argument: when group cases are established sole based on appeals from the Federal Register and the participants are subject to the substantive claim requirements in 42 C.F.R. § 413.24(j), any EJR request filed in such cases must be stayed until the participants file their cost reports and the Medicare Contractor has time to review the as-filed cost report for compliance with the § 413.24(j) substantive claim requirements. No such supplemental filing has been made regarding this *generic* contention as of this determination. Accordingly, the filing in Case No. 21-0887GC was outside the scope of the original extension request and was not timely filed under Board Rule 44.6. *See supra* note 3.

The Board's decision on jurisdiction and EJR are set forth below.

Issue in the EJR Request:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2021 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.2030% for FFY 2021.[7]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[8] known as the Inpatient Prospective Payment System (IPPS). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). The base payment rate is comprised of a standardized amount[9] for all subsection (d) hospitals located in an "urban" or "rural" area.[10]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[11] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[12]

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[7] Providers' EJR requests at 2.
[8] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[9] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[10] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[11] of the Department of Health and Human Services.
[12] https://cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/wage.

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[13]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[14] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[15] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[16] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[17]

In the FY 2020 IPPS final rule, the Secretary summarizes his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for comprehensive wage index reform given the growing disparities

[13] *Id.*
[14] 83 Fed. Reg. 20164 (May 7, 2018).
[15] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[16] *Id.*
[17] *Id.*

> between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[18]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[19] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[20]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[21] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[22]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[23] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The

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[18] 84 Fed. Reg. at 42326 (citations omitted).
[19] *Id.* at 42328.
[20] *Id.* at 42326
[21] *Id.*
[22] *Id.*
[23] *Id.*

Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[24]

Relevant here, in the FFY 2021 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[26]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[27] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . .it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[28]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[29] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[30] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we

[24] *Id.* at 42326-7
[25] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[26] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).
[27] 84 Fed. Reg. at 42329.
[28] *Id.* at 42328-9.
[29] *Id.* at 42331.
[30] *Id*.

considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[31]

The Secretary continued the low wage index hospital policy the following year, for FFY 2021, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[32]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2021 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.

The Providers note that in the FFY 2021 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E). This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level. The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States." *Id.*

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner. As a result, the Providers allege the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.2030 percent to offset the AWI increases to those hospitals in the lowest AWI quartile.[33]

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[31] *Id*.
[32] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[33] *See* 85 Fed. Reg. at 59,034; 85 Fed Reg. 78,748, 78,754 (Dec. 7, 2020) (Correction Notice updating the budget neutrality adjustment factor to 0.2030 percent).

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment.[34] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

The Providers argue that the Secretary lacks the authority to (a) continue the Low Wage Index Redistribution in the manner set forth in the FFY 2021 IPPS Final Rule; and, (b) continue to implement such policy in a budget neutral manner under the AWI statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the Providers are challenging the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the AWI congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively.

The immediate detrimental effect will be a 0.2030 percent negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2021 for every IPPS hospital, resulting in a reduction in overall IPPS payments for all IPPS hospitals, including the Providers. Further, as this is the second year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an allegedly unlawful negative adjustment in FFY 2020.

Based on the foregoing, the Providers are challenging the Low Wage Index Redistribution in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I); and (2) improperly reduced FFY 2021 IPPS payments to IPPS hospitals, including the Providers, as a result of the budget neutral implementation of the Low Wage Index Redistribution, which has been in effect since October 1, 2019, and continues through FFY 2021. The Providers seek their "proper" IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

The Providers believe EJR is appropriate because the Board has jurisdiction over these appeals, the Providers are dissatisfied with the final determination of the Secretary, but the Board lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.2030 percent reduction issued by the Secretary in the FFY 2021 IPPS Final Rule.

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[34] *See* 85 Fed. Reg. at 58,767.

Decision of the Board:

The participants that comprise the group appeals within this EJR request have filed an appeal involving FFY 2021 based on their appeal from the FFY 2021 IPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in all of the group cases at issue appealed from the FFY 2021 IPPS Final Rule.[35] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[36] and (2) the appeals were timely filed and Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained the amount in controversy calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.2030 percent (*i.e.*, the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. 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 contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. § 405.1873

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 42 C.F.R. § 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

[35] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993), CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015) *See* 42 C.F.R. § 405.1837.
[36] *See* 42 C.F.R. § 405.1837.

> (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.[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. . . .
>
> ***

[37] (Bold and underline emphasis added.)

> (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**.[38]

These regulations are applicable to the cost reporting periods in these group cases.

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

As explained above, at issue in this appeal are cost reports beginning after January 1, 2016, which are subject to 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

[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.)

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]

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[43] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such 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, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature.

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, except in one instance, no party has asserted that any of the participants in these Federal Register appeals later

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[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] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

filed its cost report and failed to properly make a cost report substantive claim for the matter at issue. The one instance where FSS made such a filing was in Case No. 21-0887GC regarding the 2 participants in that case. However, as discussed above, FSS did not timely make that challenge as required under Board Rule 44.6 and the extension request itself was too vague in that it did not state how much time was needed and only pertained to briefing the generic argument that, when group cases are established sole based on appeals from the Federal Register and the participants are subject to the substantive claim requirements in 42 C.F.R. § 413.24(j), any EJR request filed in such cases must be stayed until the participants file their cost reports and the Medicare Contractor has time to review the as-filed cost report for compliance with the § 413.24(j) substantive claim requirements.[44] Here, all of the participants in these groups are appealing the FFY 2021 Federal Register Notice and the cost reports impacted by such notice, in most cases, appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[45] In those instances where the cost report has been filed *subsequent to* these group appeals being established, no party has *timely* raised a question regarding § 413.24(j) compliance.[46]

Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[47] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[48] and

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[44] *See supra* notes 3, 5 and accompanying text (discussing how the extension request did not meet the self-effectuating extension in Board Rule 44.6 and how the extension request was too vague otherwise to be granted).
[45] *See* 80 Fed. Reg. at 70556, 70569-70.
[46] As discussed in *supra* notes 3, 5 and accompanying text, the challenge filed in Case No. 21-0887GC was not timely.
[47] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."
[48] *Id.* at 42326.

2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[49]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[50]

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[49] 84 Fed. Reg. at 42331.

[50] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

While this appeal involves the FFY 2021 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[51] The proposed rule did not propose any changes to this policy.[52] The Final Rule for FY 2021 refers to the responses to comments provided in the FY 2020 Final Rule, and applied the policy in the same manner as it was applied in FY 2020.[53] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FY 2021.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2021 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.2030 for FFY 2021. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding the FFY 2021 IPPS Final Rule, there are no findings of fact for resolution by the Board;

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

4) It is without the authority to decide the legal question of whether the Uncodified Regulation on Wage Index published in the IPPS 2021 Final Rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Regulation on Wage Index as published in the FFY 2021 IPPS Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

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[51] 85 Fed. Reg. at 58765-68.
[52] *Id.* at 58766.
[53] *Id.* at 58766, 58768.

Board Members Participating:

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

FOR THE BOARD:

8/12/2022

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)
Cecile Huggins, Palmetto GBA
Pamela VanArsdale, National Government Services, Inc. (J-6)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)
Jacqueline Vaughn, CMS OAA

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: **Denial of EJR Requests & Dismissal**
15-0751GC QRS John C. Lincoln H. Netwk CYs 2010-2011 Medicaid Fract./Dual Elig. Days CIRP
16-0582GC QRS Health First CYs 2011- 2012 DSH Medicaid Fract. Dual Eligible Days CIRP

Dear Mr. Ravindran:

The Provider Reimbursement Review Board ("Board") reviewed the pending *consolidated* request for expedited judicial review ("EJR") in the above-referenced common issue related party ("CIRP") group appeals and, on July 13, 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 August 2, 2022, the Providers' group representative, Quality Reimbursement Services ("QRS"), filed a response that confirmed the Providers still intended to pursue EJR but requested additional time to brief and respond to the Board's RFI with an updated EJR request.[1] Set forth below is the Board's determination to deny the EJR requests and dismiss the cases.

Issue in Dispute in the EJR Request

On June 17, 2022, the Providers in the above-captioned cases 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 to include these noncovered days in the Medicare fraction and the exclude the subset of those days involving dually eligible patients from the numerator of the Medicaid fraction.

Board's Scheduling Order Issued July 13, 2022

On July 13, 2022, the Board issued a Scheduling Order, requiring QRS to provide certain additional information within 21 days (*i.e*., by August 3, 2022) because the EJR Request (and any responses thereto) were submitted prior to the Supreme Court's recent ruling in *Empire* and did not discuss the

[1] QRS's response also referenced 4 Cone Health System group appeals, and the Board will issue its determination separately regarding those appeals.

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 QRS provide the following information:

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 QRS that failure 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' August 2, 2022 Response

QRS responded on August 2, 2022 at 7:51 pm *on the day before the August 3rd filing deadline*, stating:

> 1. The Board issued letters dated July 13, 2022 directing the Providers to file supplemental briefings regarding their EJR request and Single Participant Groups in light of the decision of the United States Supreme Court in *Becerra v. Empire Health Foundation*, No. 20-1312 (June 24, 2022);
>
> 2. The Providers in the captioned cases are similarly situated to the Providers in QRS University of AZ Health 2012 SSI Fraction Dual Eligible Days CIRP, *et al*., Case Nos. 15-1161GC, *et al*. With respect to the University of AZ Health cases, the Providers are preparing responses to the Board regarding the impact of Empire decision on their EJR requests and this response is due to the board by August 22, 2022. Accordingly, **the Providers in the above-captioned cases request that the Board grant an extension to their due date and allow them until August 22, 2022 to fully respond to the board** [*sic*]. This extension will allow all of the providers to respond to the virtually identical PRRB request on the same timetable.[3]

Accordingly, QRS requested an additional 20 days in which to submit the Providers' updated EJR requests.

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[2] This information is necessary for the Board to rule on the EJR request. *See* 42 C.F.R. § 405.1842(f)(2)(iii). *See also supra* note 3 in the July 13, 2022 Board Scheduling Order/RFI (discussing the fact that a group appeal may only contain one issue in order for the Board to have jurisdiction over that group).

[3] (Bold and underline emphasis added.)

Discussion and Board Decision

In responding to the Board's RFI in the 2 above-captioned CIRP groups, QRS references the proceedings of the consolidated EJR request for 8-related CIRP groups appeals under the lead appeal of Case No. 15-1161GC. Accordingly, the Board provides the following summary of key procedural events for context:

1. On June 2, 2022, QRS filed a consolidated request for EJR in Case Nos. 15-1161GC, *et al*.

2. On June 28, 2022, the Board issued an RFI to QRS requesting additional information in light of the June 24, 2022 Supreme Court Decision in *Empire* and gave QRS 21 days to respond. The Board specifically noted that: (1) the deadline was firm and exempt from the Alert 19 suspension of Board-set deadlines; and (2) "given the import of the *Empire* decision, failure of the [QRS] 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." Significantly, this RFI was ***identical*** to that issued in the 2 above-captioned CIRP groups.

3. On July 19, 2022, *the day of the deadline*, QRS requested an extension of an additional 14-days (i.e., until August 2, 2022) "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)."

4. On July 22, 2022, the Board took the following actions:

    a) Denied the extension request finding that "QRS' July 19, 2022 response is, at best, incomplete"; that "QRS' response failed to brief (as required) the *Empire* decision"; that "QRS waited until the ***final*** day to request an extension of time to respond to the Board's RFI"; and accordingly, that the deadline passed without a Board approved extension.

    b) Denied the EJR request finding that "QRS' response failed to brief (as required) the *Empire* decision"; that "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 . . ."; that, instead, "QRS has represented that there is a new and separate issue in these CIRP groups involving only the numerator of the Medicare fraction"; that "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"; and that "[a]s 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."

    c) Dismissed the CIRP groups pertaining only to the Medicaid fraction because "QRS has made clear that the new separate issue only pertains to the numerator of the Medicare fraction."

d) Issued a scheduling order for the remaining 6 CIRP group appeals ordering that, by 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" certain information specified by the Board.

Further, following this deadline, the Board noted that it would close those 6 remaining CIRP group cases as 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. As group appeals are limited to a sole legal issue, the Board directed QRS to wait to submit any EJR request on the issue for which it may request bifurcation until after the Board determined it is appropriate to grant such a request and had established a new CIRP group for that issue.

Regarding the current 2 CIRP group cases, QRS' August 2, 2022 filing was filed after-hours at 7:51 pm on the day before the deadline and was ***not*** responsive to any of the Board's requests for information. Instead, QRS "request[s] that the Board grant an extension to their due date and allow them until August 22, 2022 to fully respond to the board [*sic*]" and "allow all of the providers to respond to the virtually identical PRRB request [in Case Nos. 15-1161GC, *et a*l.,] on the same timetable." In asking for the extension, QRS incorrectly suggests that the Board had granted QRS an extension in Case No. 15-1161GC, *et al*. However, as recounted above, *10 days earlier on July 22, 2022*, the Board had already denied QRS' extension request in Case Nos. 15-1161GC, *et al*., and dismissed the EJR request *as well as the companion Medicaid fraction cases*.

Further, the fact that the Board's June 28, 2022 RFI in the above-captioned cases was the ***same*** as that issued July 13, 2002 in Case Nos. 14-1161GC, *et al*., and QRS had the benefit of the Board's July 22, 2022 denial demonstrates the hollowness of QRS' nonresponsive filing. Indeed, in Case No. 15-1161GC, *et al*., QRS had requested a 14-day extension which would have ended on August 2, 2022 (not August 22, 2022), which is the same day that QRS' response was due in the above-captioned cases. It is unclear why QRS failed to include ***any*** responsive information in its August 2nd filing in the current cases. In particular, unlike the QRS response in the *Arizona* cases for Case Nos. 15-1161GC, *et al*., the QRS response for the above-captioned cases did ***not*** state that it desired "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)." Rather, QRS simply requested an extension without explaining why one was needed or indicating what substantively needed clarification. The Board must presume that it did not include such a statement because the above captioned cases *pertain to the Medicaid fraction* (and ***not*** the SSI fraction) and, in 15-1161GC, *et al*., the Board dismissed the Medicaid fraction only cases on July 22, 20222.

Regardless, that statement would have been irrelevant because both John C. Lincoln Health Network and Health First already had an SSI Fraction Dual Eligible days CIRP group pending for the same year. Specifically, Case No. 15-0751GC is a CIRP group for John C. Lincoln Health for CYs 2010-11 pertaining to the Medicaid Fraction Dual Eligible days; however, John C. Lincoln Health Network also has pending CIRP groups for the same years pertaining to the SSI Fraction Dual Eligible Days filed by Fenix Financial Forensics, LLC under Case Nos. 14-3188GC for 2010 and 14-3802GC for 2011 (but for which EJR has ***not*** been requested). Similarly, Case No. 16-0582GC is a CIRP group for Health First for CY 2011 to 2012; however, Health First also has a CIRP group pending under Case No. 16-0584GC for the same years

pertaining to the SSI Fraction Dual Eligible Days filed by QRS (but for which EJR has ***not*** been requested). In this regard, the Board takes administrative notice that a CIRP group may contain only one legal issue and that it has generally required the formation of two separate groups for the Exhausted Part A Days issue when the issue statement for the appeal requests not just exclusion of no-pay Part A days from the Medicare fraction (aka the SSI fraction) but also the inclusion, in the Medicaid fraction, of the subset of those days for which the underlying patient was also Medicaid eligible (*i.e*., was a dual eligible) because, in that instance, there are two legal issues.[4,5] Thus, to the extent QRS were to claim that Case Nos. 15-0751GC and 15-0582GC includes the SSI Fraction Dual Eligible Days issue, then it would violate 42 C.F.R. § 405.1837(a) and be a prohibited duplicate case under Board Rule 4.6.

In summary, *consistent with the Board's July 22, 2022 ruling in Case Nos. 15-1161GC*, *et al.*, the Board takes the following actions in Case Nos. 15-0751GC and 16-0582GC:

1. Denies the extension request and denies EJR, as QRS' August 2, 2022 filing was not responsive in that it failed to address the Board's specific inquiry, and the extension request was filed right at the deadline *without Board approval* (even though approval of an extension was required in the Board's Scheduling Order and QRS had the benefit of the Board July 22, 2022 ruling in Case Nos. 15-1161GC, *et al*., particularly as it relates to the Board's dismissal of the Medicaid-fraction-only cases similar to the instant cases).

2. Pursuant to 42 C.F.R. § 405.1868(a)-(b), dismisses Case Nos. 15-0751GC and 16-0582GC in their entirety for failure to timely file their response without a Board-approved extension.

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

Board Members Participating:

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

For the Board:

8/16/2022

X Clayton J. Nix

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

cc: John Bloom, Noridian Healthcare Solutions
Geoff Pike, First Coast Service Options
Wilson Leong, FSS

[4] The Board also takes administrative notice that, when processing EJR requests on these two issues, it has been correcting any limited situations where the Board may have previously consolidated these two issues in error.
[5] As evidenced, by the 9th Circuit's decision in *Empire Health Found. v. Price*, 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. 958 F.3d 873, 886 (9th Cir. 2020).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

David Johnston, Esq.
Epstein Becker & Green, P.C.
375 N. Front Street, Suite 325
Columbus, OH 43215

RE: ***Notice of Dismissal***
Hardin Memorial Hospital (Prov. No. 36-1315)
FYE 06/30/2015
Case No. 17-1724

Dear Mr. Johnston:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Hardin Memorial Hospital's ("Provider") Individual Appeal Request on June 20, 2017. On March 25, 2020, the Board issued Alert 19, which indefinitely suspended "Board-Set Deadlines" from Friday, March 13, 2020 forward and also "encourage[d] Providers and their representatives to continue to make these filings electronically through OH CDMS, as appropriate and in keeping with public health precautions." [1].

On June 16, 2021, a Notice of Hearing was issued to the parties which required the Provider file its Final Position Paper by February 16, 2022, and also set a hearing for May 17, 2022. The Board received a change of representative notice on April 1, 2022. The Board staff attempted to contact the Provider's Representative on April 21, 2022 to inquire as to whether the Provider was still pursuing the appeal. The Provider *did no*t respond to the Board staff's inquiry.

The Provider's last filing in this case by the previous representative occurred on March 1, 2018 with the filing of its preliminary position paper ("PPP"). On April 1, 2022, a change in representation was filed wherein the representative notified the Board of a change in organization and contact information. On April 7, 2022, the representative transferred Issue 1 to Case No. 19-0154GC. As a result, the remaining issue in this case concerns physician compensation costs -anesthesiology. The Board staff attempted to contact the Provider's Representative on April 21, 2022 to inquire as to whether the Provider was still pursuing the appeal. The Provider did *no*t respond to the Board staff's inquiry.

On July 13, 2022, a Notice of Potential Dismissal was issued to the Provider ordering that the Provider's Representative respond within fifteen (15) days whether the Provider is still pursuing this appeal. The order specifically stated it was exempt from the Alert 19 suspension of Board-set deadlines and that "[f]ailure to submit a timely response to this request will result in dismissal of the case." As of the date of this letter, no response has been submitted by the Provider's representative.

Pursuant to 42 C.F.R. § 405.1868(b):

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

Having issued an order for the Provider's representative to provide a case status and advise whether the Provider is still pursuing the appeal and receiving no response, the Board hereby dismisses this case and removes it from the Board's docket pursuant to its authority under 42 C.F.R. § 405.1868(b).

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

Board Members:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

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

[1] *See also* Board Rules 4.1 & 41.2

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Jennifer Wallace
Acadiana Management Group
101 La Rue France, Suite 100
Lafayette, LA 70508

RE: ***Notice of Dismissal***
Edmond – AMG Specialty Hospital (Prov. No. 37-2005)
Case No. 20-1468

Dear Ms. Wallace:

The Provider Reimbursement Review Board ("Board" or "PRRB") received Edmond – AMG Specialty Hospital's ("Provider") Individual Appeal Request on March 4, 2020. On September 29, 2020, a Notice of Hearing was issued to the parties which required the Provider file its Final Position Paper by April 30, 2021, and also set a hearing for July 29, 2021. The Board staff contacted the Provider's Representative on June 17, 2021 and July 6, 2021 regarding the status of the hearing. The Provider responded on July 6, 2021 via email that a status update would be forthcoming the following day, July 7, 2021; however, no such update was sent. Accordingly, the Board staff again attempted to contact the Provider's Representative on June 8, 2022 to inquire as to whether the Provider was still pursuing the appeal, but again received no response.

On July 13, 2022, a Notice of Potential Dismissal was issued to the Provider ordering that the Provider's Representative respond within fifteen (15) days to provide a case status update and confirm whether the Provider is still pursuing this appeal. The order specifically exempted the deadline from the Alert 19 suspension of Board-set deadlines and stated that "[f]ailure to submit a timely response to this request will result in dismissal of the case." As of the date of this letter, no response has been submitted by the Provider's representative.

Pursuant to 42 C.F.R. § 405.1868(b):

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

[1] *See also* Board Rules 4.1 & 41.2

Having issued an order for the Provider's representative to provide a case status update and advise whether the Provider is still pursuing the appeal and receiving no response, the Board hereby dismisses this case, with prejudice, and removes it from the Board's docket pursuant to its authority under 42 C.F.R. § 405.1868(b).

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

Board Members:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Federal Specialized Services
Bill Tisdale, Novitas Solutions, Inc. (J-H)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Robert L. Roth, Esq.
Hooper, Lundy and Bookman
401 9th Street NW, Ste. 550
Washington, D.C. 20004

RE: ***Expedited Judicial Review Determination***
22-0642GC Care New England FFY 2022 Area Wage Index Standardized Amt. Reduction CIRP
22-0579GC Emory Healthcare FFY 2022 Area Wage Index Standardized Amount Reduction CIRP
22-0580GC Univ. of Chicago MC FFY 2022 Area Wage Index Standard. Amt. Reduction CIRP
22-0581GC Yale-New Haven FFY 2022 Area Wage Index Standardized Amount Reduction CIRP
22-0582GC UNC Health FFY 2022 Area Wage Index Standardized Amount Reduction CIRP Grp.
22-0599GC HCA FFY 2022 Area Wage Index Standardized Amount Reduction CIRP Group
22-0710G Hooper Lundy & Bookman FFY 2022 Area Wage Index Stand. Amt. Reduction Grp.

Dear Mr. Roth:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' *consolidated* request for expedited judicial review (EJR) filed on July 18, 2022 in the above-referenced 7 group appeals. On July 19, 2022, the Medicare Administrative Contractor (MAC) filed two individual requests for an extension of time to complete jurisdictional and substantive claim determinations *in Case Nos. 22-0599GC and 22-0710G*, arguing that jurisdictional and substantive claim aspects cannot be reviewed as many of the participants have yet to file their cost reports for one or both of their respective cost reporting periods at issue. On July 21, 2022, Federal Specialized Services (FSS) filed a *consolidated* response noting that the 7 groups span 3 different MACs, the cost reports have not been filed for the groups and the groups were all fully formed contemporaneously with the EJR request. FSS argues that Board Rules 44.6 and 22 give MACs 60 days following the receipt of the final Schedule of Providers (SOP) to review that schedule and file jurisdictional challenges, and the EJR request and corresponding timeline cannot circumvent these Rules, especially here where a final SOP is filed contemporaneously with the EJR request. Significantly, the request *failed* to state specifically how much additional time was needed for either review and to brief the challenges.

On July 28 and August 10, 2022, the Providers filed their opposition to the MAC's extension requests in Case Nos. 22-0599GC and 22-0710GC, respectively. On August 2, 2022, Providers filed their opposition to FSS' extension request.

The Board has considered the MAC's and FSS' extension requests and the Providers' opposition thereto, and **denies** these requests for an *unspecified* amount of additional time to respond to the EJR request with one exception. Here, the Providers' EJR request is based on a challenge to a Final Rule published in the Federal Register, thereby simplifying any potential jurisdictional

issues. In this regard, cost reports are not required to be filed in order for the Board to have jurisdiction over this appeal pursuant to 42 U.S.C. § 1395oo(a).[1] Further, in these cases, all of the Providers in these group appeals were direct adds, and were ***timely*** added on the same date as the initial group appeal requests. Indeed, it is clear from the OH CDMS system-generated SOPs (attached to this letter) that these appeals are timely, and the minimum amount in controversy requirement for a group appeal has been met in each of these group cases. Finally, relative to jurisdiction, the MAC and FSS have not pointed to any specific jurisdictional concern that needs further development (*e.g.,* at CIRP provider inappropriate participating in an optional group, preclusion of administrative or judicial review of the matter at issue).

This leaves the additional time requested to complete the review of potential substantive claim challenges.[2] However, in making its extension requests, the MAC and FSS failed to articulate either the amount of time needed to brief their position or a persuasive reason as to *why* they needed more time to review the cases for potential "Substantive Claim Challenges."[3] In this regard, the MAC contends that the appeals are based on an appeal of the Federal Register and, as a result, the cost reports have not been filed and the MAC needed more time to make a substantive claim determination for that reason. However, that reason is a ***generic*** argument and does *not* require participant-specific information or review. Moreover, as discussed more fully below, the Board finds that a substantive claim determination is not yet ripe in most of these cases, specifically in those instances where the appeal is filed based on a Federal Register appeal and no cost report has yet been filed (*i.e*., not been filed as late as the Medicare Contractor's review of the EJR request). In the instance where a cost report has been filed in these cases, which is only one cost report for Atrium Health Blue Ridge, Provider No. 34-0075, with FYE 12/31/2021, the extension request is now moot as the Group Representative has acknowledged that this Provider did not comply with 42 C.F.R. § 413.24(j) on that cost report.

For these reasons, the Board denies the MAC's and FSS' requests for an extension of time outside the one exception, and proceeds with an EJR determination.[4] The Board's decision on jurisdiction and EJR are set forth below.

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[1] *See Washington Hospital Center v. Bowen,* 795 F.2d 139 (D.C. Cir. 1986).

[2] The Board notes that the FSS' extension request also did not meet the following self-effectuation extension provided in Board Rule 44.6 as FSS did not include such a certification:

> If the final schedule of providers for a group appeal is filed concurrently with an EJR request, or 60 days has not yet transpired between the filing of the final SOP and the EJR request, then the Medicare contractor (or any other moving party) has five (5) business days to either: . . . .
>
> 2. Submit a filing wherein the Medicare contractor certifies that it will, in fact, be filing a challenge(s) (whether to a Jurisdictional or Substantive Claim Challenge) related to the group appeal (or participants therein, as relevant) but it has not yet had an opportunity to complete its review of the final schedule of providers and to finalize the filing for the challenge(s).

[3] As explained 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" ***as required*** *by 42 C.F.R. § 413.24(j)*.

[4] The Board recognizes that the lead Medicare Contractor in Case No. 22-0582GC later filed a Substantive Claim Challenge on August 3, 2022 (17 days after the request for EJR was filed). This Challenge was filed only in that case and was specific to one participant, Atrium Health Blue Ridge, and for a cost report period that includes only 3

Issue:

The issue for which EJR has been requested is:

> [W]hether the Providers' FFY 2022 standardized amount and hospital-specific operating IPPS [inpatient prospective payment system] payment rate[s] were improperly reduced by approximately 0.1971% for FFY 2022.[5]

Statutory and Regulatory Background:

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[6] known as the Inpatient Prospective Payment System (IPPS). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups (DRGs). The base payment rate is comprised of a standardized amount[7] for all subsection (d) hospitals located in an "urban" or "rural" area.[8]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary[9] adjust the standardized amounts "for area differences in hospital wage levels by a factor (established by the Secretary) reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level." This adjustment factor is the wage index. The Secretary currently defines hospital geographic areas (labor market areas) based on the definitions of Core-Based Statistical Areas (CBSAs) established by the Office of Management and Budget. The wage index also reflects the geographic reclassification of hospitals to another labor market area in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10).[10]

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months of the period at issue. The Group Representative has acknowledged that this Provider, Atrium Health Blue Ridge, did not comply with 42 C.F.R. § 413.24(j).

[5] Providers' EJR Request at 2.

[6] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).

[7] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww(d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor-related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).

[8] 42 U.S.C. § 1395ww(d)(2)(A)-(D).

[9] of the Department of Health and Human Services.

[10] https://cms.gov/Medicare/Medicare-Fee-For-Service-Payment/AcuteInpatientPPS/wage.

The statute further requires that the Secretary update the wage index annually, based on a survey of wages and wage-related costs of short-term, acute care hospitals. Data included in the wage index derive from the Medicare Cost Report, the Hospital Wage Index Occupational Mix Survey, hospitals' payroll records, contracts, and other wage-related documentation. In computing the wage index, the Secretary derives an average hourly wage for each labor market area (total wage costs divided by total hours for all hospitals in the geographic area) and a national average hourly wage (total wage costs divided by total hours for all hospitals in the nation). A labor market area's wage index value is the ratio of the area's average hourly wage to the national average hourly wage. The wage index adjustment factor is applied only to the labor portion of the standardized amounts.[11]

A. Changes to the Wage Index Calculation

In the FFY 2019 IPPS proposed rule,[12] the Secretary invited the public to submit comments, suggestions, and recommendations for regulatory and policy changes to the Medicare wage index. The Secretary discussed the responses it received from this request for information ("RFI") as part of the FFY 2020 IPPS proposed rule.[13] Therein, the Secretary noted that many respondents expressed: (1) "a common concern that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals"; and (2) "concern that the calculation of the rural floor has allowed a limited number of states to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities."[14] Based on these concerns, the Secretary proposed "[t]o help mitigate the wage index disparities" by "reduc[ing] the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . ."[15]

In the FY 2020 IPPS final rule, the Secretary summarizes his proposal as follows:

> [N]otwithstanding the challenges associated with comprehensive wage index reform, we agree with respondents to the request for information who indicated that some current wage index policies create barriers to hospitals with low wage index values from being able to increase employee compensation due to the lag between when hospitals increase the compensation and when those increases are reflected in the calculation of the wage index. (We noted that this lag results from the fact that the wage index calculations rely on historical data.) We also agreed that addressing this systemic issue did not need to wait for

[11] *Id.*
[12] 83 Fed. Reg. 20164 (May 7, 2018).
[13] 84 Fed Reg 19158, 19393-94 (May 3, 2019).
[14] *Id.*
[15] *Id.*

> comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure." Therefore, in response to these concerns, in the FFY 2020 LTCH PPS proposed rule . . . , we proposed a policy that would provide certain low wage index hospitals with an opportunity to increase employee compensation without the usual lag in those increases being reflected in the calculation of the wage index.[16]

In the FFY 2020 IPPS final rule, the Secretary finalized the "proposal to increase the wage index for hospitals with a wage index value below the 25th percentile wage index by half the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value across all hospitals is 0.8457."[17] In doing so, the Secretary determined that "quartiles are a reasonable method of dividing the distribution of hospitals' wage index values" and that "identifying hospitals in the lowest quartile as low wage index hospitals, hospitals in the second and third 'middle' quartiles as hospitals with wages index values that are neither low nor high, and hospitals in the highest quartile as hospitals with high wage index values, is a reasonable method of determining low wage index and high wage index hospitals for purposes of our proposals . . . addressing wage index disparities."[18]

The Secretary acknowledged that "there is no set standard for identifying hospitals as having low or high wage index values"; however, he believes his "proposed quartile approach is reasonable for this purpose, given that . . . quartiles are a common way to divide distributions, and that our approach is consistent with approaches used in other areas of the Medicare program." The Secretary stated in the proposed rule that, based on the data for the proposed rule, for FY 2020, the 25th percentile wage index value across all hospitals was 0.8482 and that this number would be updated in the final rule based on the final wage index values.[19] When the FFY 2020 IPPS final rule was published the 25th percentile wage index value across all hospitals for FFY 2020 was 0.8457.[20]

Under the Secretary's methodology, he decided to increase the wage index for hospitals with a wage index value below the 25th percentile wage index. The increase in the wage indices for these hospitals would be equal to half of the difference between the otherwise applicable final wage index value for a year for that hospital and the 25th percentile wage index value for that year for all hospitals.[21] The Secretary announced that this policy would be in effect for at least 4 years beginning in FFY 2020, in order to allow employee compensation increases implemented by low wage index value hospitals sufficient time to be reflected in the wage index calculation. The Secretary explained that, for the FFY 2020 wage index, data from 2016 cost reports was

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[16] 84 Fed. Reg. at 42326 (citations omitted).
[17] *Id.* at 42328.
[18] *Id.* at 42326
[19] *Id.*
[20] *Id.*
[21] *Id.*

used to calculate the wage indices and 4 years is the minimum time before increases in employee compensation included in Medicare cost reports could be reflected in the wage index. The Secretary acknowledged that additional time may be necessary to determine the duration of the policy.[22]

In the FFY 2021 IPPS Final Rule, the Secretary indicated he was continuing the low wage index hospital policy for FY 2021, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[23] Based on the data for this final rule, for FY 2021, the 25th percentile wage index value across all hospitals was 0.8465, which was later corrected to 0.8469.[24]

Relevant here, in the FFY 2022 IPPS Final Rule, the Secretary again indicated he was continuing the low wage index hospital policy for FY 2022, and also applying this policy in a budget neutral manner by applying an adjustment to the standardized amounts.[25] Based on the data for this final rule, for FY 2022, the 25th percentile wage index value across all hospitals was 0.8437.[26]

B. Budget Neutrality and the Wage Index

In the 2020 Proposed IPPS Rule, the Secretary explained that he believed that while it would not be appropriate to create a wage index floor or a wage index ceiling, it would be appropriate to provide a mechanism to increase the wage index of low wage index hospitals while maintaining budget neutrality for that increase through an adjustment to the wage index of high wage index hospitals. The Secretary maintains that this action has two key merits: (1) "by compressing the wage index for hospitals on the high and low ends, that is, those hospitals with a low wage index and those hospitals with a high wage index, such a methodology increases the impact on existing wage index disparities more than by simply addressing one end;" and (2) "such a methodology ensures those hospitals in the middle, that is, those hospitals whose wage indices are not considered high or low, do not have their wage index values affected by this proposed policy."[27] Thus, the Secretary concludes that, "given the growing disparities between low wage index hospitals and high wage index hospitals, . . .it would be appropriate to maintain budget neutrality for the low wage index policy proposed . . . by adjusting the wage index for high wage index hospitals."[28]

Following significant criticism from commenters to the proposed rule, the Secretary acknowledged that "some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between the proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative

[22] *Id.* at 42326-7
[23] 85 Fed. Reg. 58432, 58436 (Sept. 18, 2020).
[24] *Id.* at 58768; 85 Fed. Reg. 78748, 78754 (Dec. 7, 2020) (Correction).
[25] 86 Fed. Reg. 44774, 44778 (Aug. 13, 2021).
[26] *Id.* at 45178.
[27] 84 Fed. Reg. at 42329.
[28] *Id.* at 42328-9.

measure of the wages and wage-related costs of subsection (d) hospitals in the United States."[29] Based on this feedback, the Secretary decided to "finalize a budget neutrality adjustment for our low wage hospital policy but . . . not [to] finaliz[e] our proposal to target that budget neutrality adjustment on high wage hospitals" given that: (1) budget neutrality is required under [§ 1395ww(d)(3)(E)]; (2) even if it were not required, he believes that it would be inappropriate to use the wage index to increase or decrease overall IPPS spending; and (3) he wished to consider further the policy arguments raised by commenters regarding the budget neutrality proposal.[30] Specifically, "consistent with the Secretary's current methodology for implementing wage index budget neutrality under [§1395ww(d)(3)(E)] and the alternative approach we considered in the proposed rule (84 FR 19672), we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in the rule, was implemented in a budget neutral manner."[31]

The Secretary has continued the low wage index hospital policy the following two years, for FFY 2021 and FFY 2022, and continued to apply this policy in a budget neutral manner by applying an adjustment to the labor portion of the standardized amounts.[32]

Providers' Position:

The Providers are challenging their IPPS payments for FFY 2022 on the grounds that those payments were and continue to be improperly understated as a result of the reduction to the standardized amount, which the Secretary allegedly unlawfully imposed as part of the new policy increasing the Area Wage Index ("AWI") values of hospitals with an AWI value in the lowest quartile.

The Providers explain that the Secretary continues to implement, without any changes, his policy that increases the AWI values of hospitals with an AWI in the lowest quartile, nationally (the "Low Wage Index Redistribution") that he first adopted for FFY 2020. The Low Wage Index Redistribution was implemented in 2020 to address what the Secretary called "wage index disparities" by impacting the AWI values and the IPPS Medicare reimbursement that hospitals receive. Specifically, the Providers contend that the Low Wage Index Redistribution increases the AWI values of hospitals with AWI values in the lowest quartile, nationally, by half of the difference between their accurately calculated AWI and the 25th percentile of AWI values.

The Providers note that in the FFY 2022 IPPS Final Rule, the Secretary reiterated his assertion that he had the authority to implement this new policy under 42 U.S.C. § 1395ww(d)(3)(E). This section of the statute authorizes the Secretary to adjust the labor-related portion of IPPS payments to account "for area differences in hospital wage levels" by a "factor" (the wage index) reflecting the relative hospital wage level in the geographic area of the hospital compared to the

[29] *Id.* at 42331.
[30] *Id*.
[31] *Id*.
[32] 85 Fed. Reg. at 58436 (Sept. 18, 2020); 86 Fed. Reg. at 44778 (Aug. 13, 2021).

national average hospital wage level, citing 42 U.S.C. § 1395ww(d)(3)(E). The Secretary must "update" the wage index annually "on the basis of a survey . . . of the wages and wage-related costs of [IPPS-participating] hospitals in the United States." *Id.*

The Providers contend that the Secretary again elected to implement his Low Wage Index Redistribution in a budget neutral manner. As a result, the Providers allege, the Secretary decreased the standardized payment amounts of all IPPS hospitals by 0.1971% to offset the AWI increases to those hospitals in the lowest AWI quartile.[33]

The Providers point out that the Secretary continues to assert that he had the authority to implement this budget neutrality adjustment under 42 U.S.C. § 1395ww(d)(3)(E), however, he noted that even if he did not have such authority under § 1395ww(d)(3)(E), he would invoke is statutory "exceptions and adjustments" authority in support of such a budget neutrality adjustment.[34] This "exceptions and adjustments" authority provision, codified at 42 U.S.C. § 1395ww(d)(5)(I)(i), addresses IPPS payments and states: "The Secretary shall provide by regulation for such other exceptions and adjustments to such payment amounts under this subsection as the Secretary deems appropriate." The Providers contend that there is no statute that precludes administrative or judicial review of the Secretary's adjustments for different area wage levels under 42 U.S.C. § 1395ww(d)(3)(E) or adjustments under 42 U.S.C. § 1395ww(d)(5)(I).

The Providers argue that the Secretary lacks the authority to (a) continue the Low Wage Index Redistribution in the manner set forth in the FFY 2022 Final IPPS Rule; and, (b) continue to implement such policy in a budget neutral manner under the AWI statutory provision, the exceptions or adjustments authority, or otherwise. Therefore, the Providers are challenging the adjustment to the standardized amount on several grounds, including, but not limited to, that it exceeds statutory authority, contradicts the AWI congressional mandate, was developed in an arbitrary and capricious manner, lacks support from substantial evidence, and is otherwise defective both procedurally and substantively.

The immediate detrimental effect will be a 0.1971% negative adjustment of the standardized amount and the hospital-specific operating payment rate for FFY 2022 for every IPPS hospital, resulting in a reduction in overall IPPS payments for all IPPS hospitals, including the Providers. Further, as this is the third year of the implementation of the Low Wage Index Redistribution and the related budget neutrality adjustment, the Providers already suffered an unlawful negative adjustment in FFY 2020 and FFY 2021.

Based on the foregoing, the Providers are challenging the Low Wage Index Redistribution in this group appeal for several reasons, including but not limited to, whether the Secretary (1) improperly exercised the authority granted through 42 U.S.C. § 1395ww(d)(3)(E) and 42 U.S.C. § 1395ww(d)(5)(I); and (2) improperly reduced FFY 2022 IPPS payments to IPPS hospitals, including the Providers, as a result of the budget neutral implementation of the Low

[33] 86 Fed. Reg. at 45532 (Aug. 13, 2021); 86 Fed. Reg. at 58025 (Oct. 20, 2021).
[34] 86 Fed. Reg. at 45180 (Aug. 13, 2021).

Wage Index Redistribution, which has been in effect since October 1, 2019, and continues through FFY 2022. The Providers seek their proper IPPS payments plus interest calculated under 42 U.S.C. § 1395oo(f)(2) and/or 42 U.S.C. § 1395g(d).

The Providers believe EJR is appropriate because the Board has jurisdiction over the appeals, the Providers are dissatisfied with the final determination of the Secretary, but lacks the authority to decide the question at issue and cannot grant the relief sought. Pursuant to 42 C.F.R. § 405.1867, the Board must comply with all the provisions of Title XVIII of the Social Security Act and is therefore, bound to apply the 0.1971% reduction issued by the Secretary in the FFY 2022 IPPS Final Rule.

Decision of the Board:

The participants that comprise the group appeals within this EJR request have filed an appeal involving FFY 2022 based on their appeal from the FFY 2022 IPPS Final Rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in all of the group cases at issue appealed from the FFY 2022 IPPS Final Rule.[35] The Board has determined that (1) the participants' documentation in each of the group appeals shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal;[36] (2) the appeals were timely filed; and (3) Board review of the matter in these appeals is not precluded by statute or regulation. In finding that the groups meet the $50,000 amount in controversy, the Board recognizes that the Group Representative has explained that the amount in controversy (AiC) calculation is simply based on the estimated IPPS payments for the period at issue multiplied by 0.1971 percent (*i.e.,* the adjustment to the wage index that they are challenging in this appeal) and this AiC unmistakably demonstrates each of the groups more than clears the minimum $50,000 AiC hurdle. 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 contractors for the actual final amounts in each case.

B. Application of 42 C.F.R. § 405.1873

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 42 C.F.R. § 413.24(j) requires that:

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[35] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, CCH Medicare & Medicaid Guide ¶ 41,025, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015) *See* 42 C.F.R. § 405.1837.
[36] *See* 42 C.F.R. § 405.1837.

> (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—
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> (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
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> (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.
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> (2) *Self-disallowance procedures*. In order to properly self-disallow a specific item, the provider must—
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> (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
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> (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

[37] (Bold and underline emphasis added.)

> 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.
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> (b) *Summary of Procedures*.
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> ***
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> (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. . . .
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> ***
>
> (d) *Two types of Board decisions that must include any factual findings and legal conclusions under paragraph (b)(1) of this section-*
>
> ***
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> (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**.[38]

These regulations are applicable to the cost reporting periods in these group cases.

[38] (Bold and underline emphasis added.)

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

As explained above, at issue in this appeal are cost reports beginning after 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]

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[43] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such evidence and argument and prepare written specific findings of fact and conclusions of law on the question of whether the

[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] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

> provider's cost report complied with, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would not stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature.

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, except in one instance, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report and failed to properly make a cost report substantive claim for the matter at issue.

The one instance where FSS made such a filing was in Case No. 22-0582GC regarding one participant in that case. Specifically, FSS filed a challenge involving Atrium Health Blue Ridge, Provider No. 34-0075, with FYE 12/31/2021 in connection with a cost report filed subsequent to the group appeal. As discussed above, the timeliness of FFS' extension request in connection to this Provider is now moot as the Group Representative responded to FSS' substantive claim challenge, and admits that this Provider, Atrium Health Blue Ridge, did not comply with 42 C.F.R. § 413.24(j). In this regard, the Provider itself in making the admission has raised a question under § 405.1873(a) to trigger Board review of compliance with § 413.24(j).

As such, since ***both parties*** to the appeal have questioned, pursuant to § 405.1873(a), whether an appropriate claim was made for this Provider (as well as the fact that the Provider's noncompliance with § 413.24(j) is undisputed between the parties),[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. The Board notes that because the Provider has admitted to the fact that it did not self-disallow, 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 the Provider's 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

[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."

> 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.

a) Findings on Atrium Health Blue Ridge's Compliance with § 413.24(j)

Applying that regulation to Atrium Health Blue Ridge, Provider No. 34-0075, the cost report for FYE 12/31/2021 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 admitted that it failed to comply with the substantive claim requirement in 42 C.F.R. § 413.24(j).

[45] *See* 42 C.F.R. § 413.24(j)(3).

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 Atrium Health Blue Ridge failed to make a substantive claim pursuant to 42 C.F.R. § 413.24(j)(1)-(2) in the cost report that has been filed, which is for the FYE 12/31/2021.[46]

The Board notes that the Group Representative has indicated that if this finding was made, the Board was also on notice that this Provider challenges the validity of the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1873. As there are no factual disputes regarding Atrium Health Blue Ridge, the Board may consider that challenge, in the form of a request for EJR on the validity of the substantive claim regulations, as set forth below in Section C below.

b) All Other Participants in These Group Cases

Here, all of the remaining participants in the above-referenced group cases are appealing the FFY 2022 Federal Register Notice and the cost reports impacted by such notice appear to have not yet been filed to trigger § 413.24(j)'s general substantive payment requirement for cost reports.[47] Accordingly, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases for any of the remaining participants.

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

While the Provider Atrium Health Blue Ridge plainly admits that it did not protest the AWI issue on its cost report for FYE 12/31/2021, the Provider also asserts that the self-disallowance regulation at 42 C.F.R. § 413.24(j) is invalid. Moreover, the Provider's Representative has essentially requested EJR over the validity of 42 C.F.R. § 413.24(j) in addition to the AWI issue (discussed more fully, below).[48]

The Provider asserts that the "refabricated" self-disallowance provision in § 413.24(j) conflicts with 42 U.S.C. § 1395oo and the decision of the Supreme Court in *Bethesda Hospital Ass'n v. Bowen,* 485 U.S. 399 (1998).[49] Further, the Provider argues that CMS' adoption of the self-disallowance requirement and any attempt to apply it in this appeal are procedurally and/or substantively invalid for multiple additional reasons, including, but not limited to, the following: (1) it was arbitrary and capricious for numerous reasons, including that CMS' asserted rationale for the policy has no applicability to regulatory challenges that the MAC is powerless to correct; (2) before Blue Ridge Hospital filed the cost report at issue, it had already explicitly protested the AWI issue by filing the group appeal, and thus CMS and the MAC had already been notified that this Provider was protesting its FFY 2022 IPPS rates based on the AWI issue; (3) before Blue Ridge Hospital filed the cost report at issue, other hospitals had already been litigating the AWI issue, and thus CMS was on notice that hospitals are challenging the IPPS rates on the AWI issue; and (4) CMS failed to meet the procedural requirements for the adoption of this

[46] The Board recognizes that the Group Representative has presented a challenge to the regulation at 42 C.F.R. § 413.24(j).
[47] *See* 80 Fed. Reg. at 70556, 70569-70.
[48] Provider's Response to MAC's Substantive Claim Challenge at 13-14.
[49] *Id.* at 1, 8-10, 13.

requirement under both the Medicare Act and the Administrative Procedure Act, 5 U.S.C. §§ 551 *et seq.*, including by failing to provide adequate notice and opportunity for comment when adopting the self-disallowance requirement.[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 challenge made by Atrium Health Blue Ridge regarding the validity of 42 C.F.R. §§ 413.24(j) is relevant to the matter at issue in these group appeals.[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 Atrium Health Blue Ridge's challenge to the validity of 42 C.F.R. § 413.24(j). 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. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to finalize a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals was implemented in a budget neutral manner was made through notice and comment in the form of an uncodified regulation.[52] Specifically, in the preamble to FFY 2020 IPPS Final Rule, the Secretary announced the following wage index issues:

1. "To help mitigate . . . wage index disparities [between high and low wage index hospitals], including those resulting from the inclusion of hospitals with rural reclassifications under 42 CFR 412.103 in the calculation of the rural floor, . . . we . . . reduce the disparity between high and low wage index hospitals by increasing wage index values for certain low wage index hospitals with low wage index values and decreasing the wage index values for certain hospitals with high

[50] *Id.* at 13-14.

[51] The Board recognizes that this question relates only to Atrium Health Blue Ridge 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 Atrium Health Blue Ridge.

[52] *See* 84 Fed. Reg. 42044, 42325-36 "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals."

> wage index values to maintain budget neutrality, and changing the calculation of the rural floor . . . .";[53] and
>
> 2. "[A]ddressing this systemic issue does not need to wait for comprehensive wage index reform given the growing disparities between low and high wage index hospitals, including rural hospitals that may be in financial distress and facing potential closure."

The Secretary did not incorporate the above new policy setting forth a modification to the wage index calculation determination by finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that there was an increase in the wage index for low wage index hospitals into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS Final Rule that the Secretary intended to bind the regulated parties and establish a binding uniform payment policy through formal notice and comment:

> We acknowledge, however, that some commenters have presented reasonable policy arguments that we should consider further regarding the relationship between our proposed budget neutrality adjustment targeting high wage hospitals and the design of the wage index to be a relative measure of the wages and wage-related costs of subsection (d) hospitals in the United States. Therefore, given that budget neutrality is required under section 1886(d)(3)(E) of the Act, given that even if it were not required, we believe it would be inappropriate to use the wage index to increase or decrease overall IPPS spending, and given that we wish to consider further the policy arguments raised by commenters regarding our budget neutrality proposal, we are finalizing a budget neutrality adjustment for our low wage hospital policy, but we are not finalizing our proposal to target that budget neutrality adjustment on high wage hospitals. Instead, consistent with CMS's current methodology for implementing wage index budget neutrality under section 1886(d)(3)(E) of the Act and the alternative approach we considered in the proposed rule . . . we are finalizing a budget neutrality adjustment to the national standardized amount for all hospitals so that the increase in the wage index for low wage index hospitals, as finalized in this rule, is implemented in a budget neutral manner.[54]

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Regulation on Wage Index." Indeed, this finding is consistent with the Secretary's obligations under 42 U.S.C.

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[53] *Id.* at 42326.
[54] 84 Fed. Reg. at 42331.

§ 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[55]

While this appeal involves the FFY 2022 IPPS Final Rule, the continuation of this policy was implemented in the same way as it was initially for FFY 2020.[56] The proposed rule did not propose any changes to this policy.[57] The Final Rule for FFY 2022 refers to the responses to comments provided in the FFY 2020 Final Rule, and applied the policy in the same manner as it was applied in FFY 2020.[58] Therefore, the Board finds that this policy continues to be a binding but uncodified regulation for FFY 2022.

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to apply the Uncodified Regulation on Wage Index published in the FFY 2022 IPPS Final Rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Regulation on Wage Index which they allege improperly reduces the standardized amount of 0.1971% for FFY 2022. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Requests

The Board finds that:

1) It has jurisdiction over both the AWI Issue for the subject year in these cases ***and*** the challenge made therein by Atrium Health Blue Ridge to the validity of 42 C.F.R. § 413.24(j) for the subject year and that the Providers in these group appeals are entitled to a hearing before the Board;

2) The Providers appealed cost reporting periods beginning after January 1, 2016, and the Board makes the following finding on one participant in Case No. 22-0582GC pursuant to 42 C.F.R. § 405.1873(b):

    - It is undisputed that Atrium Health Blue Ridge (Provider No. 34-0075) 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), in the cost report for the FYE 12/31/2021;

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[55] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[56] 86 Fed. Reg. at 44778 (Aug. 13, 2021).
[57] *Id.* at 45178-80.
[58] *Id.*

3) Based upon the Providers' assertions regarding the FFY 2022 IPPS Final Rule, 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 questions of whether the Uncodified Regulation on Wage Index published in the FFY 2022 IPPS Final Rule is valid ***and,*** with respect to Atrium Health Blue Ridge, 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 for the issues and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these group cases, the Board hereby closes these cases.

Board Members Participating:

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

FOR THE BOARD:

8/17/2022

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)
Cecile Huggins, Palmetto GBA
Pamela VanArsdale, National Government Services, Inc. (J-6)
Dana Johnson, Palmetto GBA c/o National Government Services, Inc. (J-M)
Byron Lamprecht, WPS Government Health Administrators (J-5)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
13-2059G - Southwest Consulting 2009 DSH Medicaid Fraction Part C Days Group
13-2061G - Southwest Consulting 2009 DSH SSI Fraction Part C Days Group
14-3206G - Southwest Consulting UC Health 2011 DSH SSI Fraction Part C Days CIRP Group
14-3209G - Southwest Consulting UC Health 2011 DSH Medicaid Fraction Part C Days CIRP Group
14-3869G - Southwest Consulting SEH 2011 DSH Medicaid Fraction Part C Days CIRP Group

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) in the above-referenced appeals. The EJR request was filed on June 30, 2022.[1]

In re: Allina II-Type DSH Adjustment Cases and the Administrator's Remand and Order

The above-referenced common issue related party ("CIRP") group appeals[2] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

In 2017, the Board granted EJR for the above referenced appeals, after concluding that it lacked jurisdiction over specific Providers/Fiscal Year Eds (FYE's) because those hospitals failed to claim or protest the Part C issue on their cost reports for periods ending on or after December 31, 2008.[3] The Board's jurisdictional dismissals relied on a now-superseded 2008 regulation, commonly known as the "self-disallowance regulation," which required for jurisdiction a hospital to have identified on its cost report as a protested item any claim for which it believed it was prevented by CMS policy from seeking reimbursement, provided there was not an audit adjustment related to that claim.[4]

[1] The request for EJR covered six appeals, including 14-3870GC. That appeal was addressed under separate cover.
[2] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[3] Board's EJR Determination (Jul. 25, 2017), PRRB Case No. 13-2059G.
[4] *Id.*

In 2017 and 2018, the Providers in the above-captioned appeals filed complaints in the D.C. District Court challenging the Board's dismissal of their respective cases for lack of jurisdiction over the Part C issue.[5] In April 2018, the agency issued CMS Ruling 1727-R announcing that the agency would acquiesce in the *Banner* decision, and apply the court's holding in future cases. The Court consolidated the Providers' court actions into the following consolidated matter: *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C). On December 2, 2021, the Providers, among other hospitals, and the Secretary, submitted a joint status report requesting that the D.C. District Court vacate these Board jurisdictional dismissals made under the 2008 self-disallowance regulation and remand their cases to the Secretary. Four days later, the Court issued an order granting that request.

On June 3, 2022, the CMS Administrator issued an Order responding to the Court's order.[6] The Administrator remanded these cases to the Board and ordered that "the Board shall revisit the remanded cases, consistent with the court's order and the Secretary's acquiescence in [*Banner*]."[7] As noted in the footnote appended to this order, the Secretary's acquiescence is embodied in CMS Ruling 1727-R.[8]

The Administrator's Order further specifies that, in those instance where the Board determined "but for the 2008 self-disallowance regulation – it has jurisdiction, the [Board] 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."[9] Notably, consistent with the Court's Order, the 2008 self-disallowance regulation, 42 C.F.R. § 1835(a)(1)(ii) (2008), cannot be a basis for the Board to find it lacks jurisdiction.[10] Finally, the Administrator's Order specifies that that "[s]ince Administrator Ruling 1739 *does* ***not*** *apply* to these judicially remanded claims, *it also* ***cannot*** *be the basis for remanding* otherwise jurisdictionally proper claims to the MAC."[11]

The Administrator's Order directs that the Board's 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.[12]

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[5] *Id*.; *See Adcare Hospital et al. v. Becerra*, 17-cv-1896 (D.D.C.); *St. Mary's Health Care System et al. v. Becerra*, 17-cv-2106 (D.D.C.).
[6] CMS Administrator's Order (Jun. 3, 2022).
[7] *Id*. at 3 (footnote omitted).
[8] *Id.* at 3 n.1.
[9] *Id.* at 3.
[10] *Id*. at 3 n.2.
[11] *Id*. at 3 n.3 (emphasis added).
[12] *Id*.

EJR Request

On June 30, 2022, the Providers filed a Petition for EJR for the providers remanded in the referenced appeals, in the Administrator's Order.[13] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. The request for EJR was filed less than 30 days' after the Administrator's remand was issued, and before the Board was able to process the remand and reopen the appeals. On July 27, 2022, the Board reopened the four appeals addressed in this decision, as well as 27 other appeals. The Board *only* considered the EJR ripe for review ***as of the date the appeals were reopened*** and specified that, pursuant to 42 C.F.R. § 405.1842(b)(2), the 30-day period for review could not (and did not) begin until the Board had reopened the cases ***and*** finds jurisdiction over the remanded cases and underlying participants.

The Providers' request for Expedited Judicial Review ("EJR") of the "MAC's treatment of the Medicare Part C Days in the DSH calculation issue" and, thereby, challenged the Secretary's Part C days policy as adopted in the FY 2005 IPPS final rule.[14,15] The Providers further ask the Board to grant EJR despite the issuance of CMS Ruling 1739-R and, in turn, challenge the validity of said Ruling.[16] Finally, the EJR asserts that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions and, in turn, challenge the validity of the Administrator's Remand Order.[17] The Providers note that the Board is bound by the Part C days policy as adopted by final rule, Ruling 1739-R and the Administrator's Order and requests EJR relative to each of those authorities. The Board's decision to deny the Provider's EJR Request is set forth below.

Statutory and Regulatory Background

Medicare Advantage Program

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

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[13] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 13-2059GC.
[14] 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004) (adopting the uncodified policy). The Secretary later codified this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (*i.e.*, incorporated into the Code of Federal Regulations) as part of the FY 2008 IPPS final rule. *See* 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[15] *Id*, at 10
[16] *Id*, at 15.
[17] *Id*, at 2.

In the September 4, 1990 Federal Register, the Secretary[18] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[19]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[20]

With the creation of Medicare Part C in 1997,[21] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[22]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A

[18] of Health and Human Services.
[19] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[20] *Id.*
[21] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[22] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> *. . . . once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[23]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[24] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[25]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[26] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[27] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010,

[23] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[24] 69 Fed. Reg. at 49099.
[25] *Id.* (emphasis added).
[26] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[27] *Id*. at 47411.

CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[28]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[29] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[30] In *Allina Health Services v. Price* ("*Allina II*")*,*[31] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[32] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[33] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[34]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[35] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[36] The

[28] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[29] 746 F. 3d 1102 (D.C. Cir. 2014).
[30] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[31] 863 F.3d 937 (D.C. Cir. 2017).
[32] *Id.* at 943.
[33] Id. at 943-945.
[34] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[35] CMS Ruling 1739-R (Aug. 17, 2020).
[36] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[37]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[38]

[37] *Id*.
[38] CMS Ruling 1739-R at 6-7.

Provider's Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal years 2009 and 2011 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[39] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[40] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[41] As such, the Providers conclude that the Board is "required" to grant EJR.[42]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[43] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[44]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[45]
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> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[39] EJR Request at 1.
[40] *Id*. at 1.
[41] *Id*.
[42] *Id*. at 1-2.
[43] *Id*. at 11-12.
[44] *Id*. at 21.
[45] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[46]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[47]

Further, the Providers argue that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions.[48] They add:

> The CMS Administrator's June 3, 2022, order ("Administrator's Order") similarly and improperly treats the Providers' appeals as moot by directing the Board to remand those cost years that are jurisdictionally proper to the MAC for recalculation of the DSH payment adjustment in accordance with the forthcoming final Part C rule. However, the Administrator's Order and the August 2020 CMS Ruling 1739-R both call for the Board to determine its jurisdiction over Part C appeals, and do not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions.[49]

The Providers assert that like the Administrator's Order, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals.[50] They argue that this approach is again consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction. While the Ruling explains in its discussion of Board jurisdiction that the Board has been granting EJR for Part C appeals, as required by the Medicare statute and regulations, it does not direct any specific action by the Board on such EJR requests, or attempt to relieve the Board of its mandatory statutory and regulatory obligation to make EJR determinations.[51]

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[46] *Id*. at 14.
[47] *Id.* at 17.
[48] Providers' Petition for Expedited Judicial Review, at 2.
[49] *Id*.
[50] *Id*. at 20.
[51] *Id*. at 20-21.

They argue that with the Administrator's Order, along with the continued presence of Ruling 1739-R, the agency has still not acquiesced in the *Allina* decisions, and has issued the Administrator's Order and promulgated CMS Ruling 1739-R in furtherance of this non-acquiescence.[52] As such, this situation is what EJR was meant to address for the Providers.

Board's Decision and Analysis

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

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

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

The third issue is a challenge to the validity of the Administrator's Order that, if the Board finds jurisdiction, it "remand the cases to the appropriate [MAC] to recalculate the DSH payment adjustments for Part C patient days in accordance with the forthcoming new rule . . . ."

A. Board's Authority

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

The Board's analysis is detailed below.

B. Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[52] *Id*. at 26.

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[53, 54]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2009 or 2011.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, the Providers were subject to the claim or protest requirements in 42 C.F.R. § 4051835(a)(1)(ii). However, the Administrator's Remand Order directs the Board to not apply that regulation, but rather apply the Secretary's acquiescence to the *Banner* decision as embodied in CMS Ruling 1727-R. CMS Ruling CMS-1727-R addresses dissatisfaction with the Medicare Contractor determinations and specifies that "assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought."[55]

In each of these cases, Part C days were either specifically adjusted, or filed under protest, and under the available directives in CMS Ruling 1727-R, the Board finds that the applicable Providers filed jurisdictionally valid appeals of the Part C days issue because the Providers are challenging the regulation governing treatment of Part C days in the DSH calculation and, thus, had "a good faith belief that the item [in this appeal] was subject to a payment regulation . . . that gave the MAC no authority or discretion to make payment in the manner the provider sought." Moreover, the appeals were timely filed and Board review of the matter at issue is not precluded by statute or regulation.

C. Medicare Part C Days Issue

The appeals involve the 2009 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. For the time periods at issue in this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any

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[53] 42 C.F.R. § 405.1835(a).
[54] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).
[55] CMS Ruling 1727-R at 2. Under ruling 1727-R, 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.

guidance on how the *vacatur* is being implemented (*e.g.*, only circuit-wide versus nationwide).[56] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[57]

However, the Board hereby denies the EJR request relative to the Part C days issue because the Administrator's Order mandates that the Board remand the Providers if it finds jurisdiction over the Providers. Since the Board has found jurisdiction, the Board must remand and never has an opportunity to consider the merits of this cases, including but not limited to the Providers' EJR request. Accordingly, the Board will remand the Providers under separate cover.

D. Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[58]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[59] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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[56] *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[57] *See* 42 U.S.C. § 1395oo(f)(1).
[58] EJR Request at 17.
[59] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[60]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. However, the Administrator's Order makes clear that "Administrator Ruling 1739 does ***not apply*** to these judicially remanded claims and therefore also could not affect the Board's jurisdiction over these cases."[61] Accordingly, CMS Ruling 1727-R is not applicable in these cases and, accordingly, the Board denies the Providers EJR request challenging the validity of 1727-R.

E. Validity of the Administrator's Order

Finally, the Providers' challenge to the Administrator's Order is outside the scope of the regulation governing EJRs.

42 C.F.R. § 405.1842(a)(1) address the basis and scope of an EJR request:

> 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***).[62]

Thus, the lack of authority to decide the legal question then is described in § 405.1867 which states:

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[60] *See Southwest* at 6-7.
[61] Administrator's Order at 3 n. 2.
[62] (Emphasis added.)

> § 405.1867 *Scope of Board's legal authority*.
>
> In 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, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[63]

Significantly, § 405.1867 only lists authorities that are published for the general public and apply to all or certain classes of providers, namely statutes, regulations, and CMS Rulings. Here, the Providers are challenging the Administrator's Order (and not the authority by which it was issue, *i.e.*, § 405.1877) and the Order is not a statute, regulation or a CMS Ruling. Moreover, the Order was not issued to apply generally to providers or classes of providers. Rather, the Order was issued for a particular set of providers in specified cases pursuant to a regulation, § 405.1877(g)(2) (which again is not being challenged). Accordingly, the Board denies the EJR request challenging the Administrator's Order because it is beyond the scope of an EJR request. Rather, the Providers may have appeal rights relative to the Board's decision here and its application of the Administrator's Order, as appropriate and relevant, under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of the remanded providers within the instant group appeals, for the days *before* October 1, 2013, pursuant to CMS Ruling 1727-R;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to the directives of the Administrator's Remand Order, the Providers will receive a remand letter of this issue under separate cover;

3) The Board hereby **denies** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider. As indicated by the Administrator's ruling and Order, Ruling 1739-R is not implicated within this specific remand; and

[63] (Bold and underline emphasis added.)

4) The Board hereby denies EJR for the Providers for the limited question of the validity of the Administrator's Remand Order as that challenge is outside the scope of the EJR regulation.

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

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Remand Letter***
13-2059G - Southwest Consulting 2009 DSH Medicaid Fraction Part C Days Group
13-2061G - Southwest Consulting 2009 DSH SSI Fraction Part C Days Group
14-3206GC - Southwest Consulting UC Health 2011 DSH SSI Fraction Part C Days CIRP Grp.
14-3209GC - Southwest Consulting UC Health 2011 DSH Medicaid Fract. Part C Days CIRP Grp.
14-3869GC - Southwest Consulting SEH 2011 DSH Medicaid Fraction Part C Days CIRP Grp.

Dear Ms. Webster:

The above-referenced group appeals include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

Pursuant to the June 3, 2022, CMS Administrator Order, responding to the Court's order in *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C), the Board reopened the above identified cases on July 27, 2022 for certain Providers remanded in those cases. The Administrator's Order directs the Board to determine whether it has jurisdiction over the remanded Providers, and if so, "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."[1]

On June 30, 2022, the Providers' Representative filed a Petition for EJR for the remaining providers remanded in the cases.[2] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. On August 17, 2022, the Board found that it had jurisdiction over the remanded Providers but denied the Providers' EJR request. The Board further noted that, consistent with the Administrator's Remand Order, it would proceed with the remand to the MAC.

[1] CMS Administrator's Order, at 3 (emphasis added).
[2] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 13-2059G.

As it has jurisdiction over the providers remanded in the above-captioned cases, the Board hereby remands to the MAC and orders the following actions relative to these providers pursuant to the Administrator's Remand Order:

- The MAC shall 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[3];

- 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).

The Board closes the group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Danelle Decker, National Government Services, Inc. (J-K)
Judith Cummings CGS Administrators (J-15)

[3] The Board notes that SEH had a companion 2011 CIRP group under Case No. 14-3870GC.for Part C days as it relates to Part C Days in the SSI fraction and the Board previously granted EJR for Case No. 14-3870GC on July 20, 2017. Thus, to the extent the sole provider remanded in the SEH 2011 CIRP group under Case No. 14-3869GC is also a participant in the companion CIRP group, this remand should be consistent, as appropriate, with the disposition of the companion CIRP group as it relates to this provider.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Expedited Judicial Review Determination***
14-4382G - Akin Gump 2010 SSI Fraction Medicare Advantage Days Group
14-4383G - Akin Gump 2010 Medicaid Fraction Medicare Advantage Days Group
15-2646G - Akin Gump 2011 Medicare Fraction Medicare Advantage Days Group
15-2647G - Akin Gump 2011 DSH Medicaid Fraction Medicare Advantage Days Grp

Dear Ms. Webster:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) in the above-referenced appeals. The EJR request was filed on June 30, 2022.

In re: Allina II-Type DSH Adjustment Cases and the Administrator's Remand and Order

The above-referenced common issue related party ("CIRP") group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

In 2017, the Board granted EJR for the above referenced appeals, after concluding that it lacked jurisdiction over specific Providers/Fiscal Year Eds (FYE's) because those hospitals failed to claim or protest the Part C issue on their cost reports for periods ending on or after December 31, 2008.[2] The Board's jurisdictional dismissals relied on a now-superseded 2008 regulation, commonly known as the "self-disallowance regulation," which required for jurisdiction a hospital to have identified on its cost report as a protested item any claim for which it believed it was prevented by CMS policy from seeking reimbursement, provided there was not an audit adjustment related to that claim.[3]

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] Board's EJR Determination (Jul. 25, 2017), PRRB Case No. 13-2059G.
[3] *Id.*

In 2017 and 2018, the Providers in the above-captioned appeals filed complaints in the D.C. District Court challenging the Board's dismissal of their respective cases for lack of jurisdiction over the Part C issue.[4] In April 2018, the agency issued CMS Ruling 1727-R announcing that the agency would acquiesce in the *Banner* decision, and apply the court's holding in future cases. The Court consolidated the Providers' court actions into the following consolidated matter: *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C). On December 2, 2021, the Providers, among other hospitals, and the Secretary, submitted a joint status report requesting that the D.C. District Court vacate these Board jurisdictional dismissals made under the 2008 self-disallowance regulation and remand their cases to the Secretary. Four days later, the Court issued an order granting that request.

On June 3, 2022, the CMS Administrator issued an Order responding to the Court's order.[5] The Administrator remanded these cases to the Board and ordered that "the Board shall revisit the remanded cases, consistent with the court's order and the Secretary's acquiescence in [*Banner*]."[6] As noted in the footnote appended to this order, the Secretary's acquiescence is embodied in CMS Ruling 1727-R.[7]

The Administrator's Order further specifies that, in those instance where the Board determined "but for the 2008 self-disallowance regulation – it has jurisdiction, the [Board] 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."[8] Notably, consistent with the Court's Order, the 2008 self-disallowance regulation, 42 C.F.R. § 1835(a)(1)(ii) (2008), cannot be a basis for the Board to find it lacks jurisdiction.[9] Finally, the Administrator's Order specifies that that "[s]ince Administrator Ruling 1739 *does* ***not*** *apply* to these judicially remanded claims, *it also* ***cannot*** *be the basis for remanding* otherwise jurisdictionally proper claims to the MAC."[10]

The Administrator's Order directs that the Board's 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.[11]

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[4] *Id*.; *See Adcare Hospital et al. v. Becerra*, 17-cv-1896 (D.D.C.); *St. Mary's Health Care System et al. v. Becerra*, 17-cv-2106 (D.D.C.).
[5] CMS Administrator's Order (Jun. 3, 2022).
[6] *Id*. at 3 (footnote omitted).
[7] *Id.* at 3 n.1.
[8] *Id.* at 3.
[9] *Id*. at 3 n.2.
[10] *Id*. at 3 n.3 (emphasis added).
[11] *Id*.

EJR Request

On June 30, 2022, the Providers filed a Petition for EJR for the providers remanded in the referenced appeals, in the Administrator's Order.[12] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. The request for EJR was filed less than 30 days' after the Administrator's remand was issued, and before the Board was able to process the remand and reopen the appeals. On July 27, 2022, the Board reopened the four appeals addressed in this decision, as well as 27 other appeals. The Board *only* considered the EJR ripe for review ***as of the date the appeals were reopened*** and specified that, pursuant to 42 C.F.R. § 405.1842(b)(2), the 30-day period for review could not (and did not) begin until the Board had reopened the cases ***and*** finds jurisdiction over the remanded cases and underlying participants.

The Providers' request for Expedited Judicial Review ("EJR") of the "MAC's treatment of the Medicare Part C Days in the DSH calculation issue" and, thereby, challenged the Secretary's Part C days policy as adopted in the FY 2005 IPPS final rule.[13,14] The Providers further ask the Board to grant EJR despite the issuance of CMS Ruling 1739-R and, in turn, challenge the validity of said Ruling.[15] Finally, the EJR asserts that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions and, in turn, challenge the validity of the Administrator's Remand Order.[16] The Providers note that the Board is bound by the Part C days policy as adopted by final rule, Ruling 1739-R and the Administrator's Order and requests EJR relative to each of those authorities. The Board's decision to deny the Provider's EJR Request is set forth below.

Statutory and Regulatory Background

Medicare Advantage Program

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

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[12] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 13-2059GC.
[13] 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004) (adopting the uncodified policy). The Secretary later codified this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (*i.e*., incorporated into the Code of Federal Regulations) as part of the FY 2008 IPPS final rule. *See* 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[14] *Id*, at 10
[15] *Id*, at 15.
[16] *Id*, at 2.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[18]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[21]

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

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A

[17] of Health and Human Services.
[18] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015*, codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> *. . . . once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[22]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

> *. . . We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction . . . .* if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010,

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[22] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[23] 69 Fed. Reg. at 49099.
[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.

CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In *Allina Health Services v. Price* ("*Allina II*")*,*[30] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[31] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[32] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[33]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[34] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[35] The

[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] 863 F.3d 937 (D.C. Cir. 2017).
[31] *Id.* at 943.
[32] Id. at 943-945.
[33] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[34] CMS Ruling 1739-R (Aug. 17, 2020).
[35] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[36]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[37]

[36] *Id*.
[37] CMS Ruling 1739-R at 6-7.

Provider's Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal years 2010 and 2011 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[38] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[39] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[40] As such, the Providers conclude that the Board is "required" to grant EJR.[41]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[42] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[43]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[44]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[38] EJR Request at 1.
[39] *Id*. at 1.
[40] *Id*.
[41] *Id*. at 1-2.
[42] *Id*. at 11-12.
[43] *Id*. at 21.
[44] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[45]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[46]

Further, the Providers argue that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions.[47] They add:

> The CMS Administrator's June 3, 2022, order ("Administrator's Order") similarly and improperly treats the Providers' appeals as moot by directing the Board to remand those cost years that are jurisdictionally proper to the MAC for recalculation of the DSH payment adjustment in accordance with the forthcoming final Part C rule. However, the Administrator's Order and the August 2020 CMS Ruling 1739-R both call for the Board to determine its jurisdiction over Part C appeals, and do not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions.[48]

The Providers assert that like the Administrator's Order, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals.[49] They argue that this approach is again consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction. While the Ruling explains in its discussion of Board jurisdiction that the Board has been granting EJR for Part C appeals, as required by the Medicare statute and regulations, it does not direct any specific action by the Board on such EJR requests, or attempt to relieve the Board of its mandatory statutory and regulatory obligation to make EJR determinations.[50]

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[45] *Id*. at 14.
[46] *Id.* at 17.
[47] Providers' Petition for Expedited Judicial Review, at 2.
[48] *Id*.
[49] *Id*. at 20.
[50] *Id*. at 20-21.

They argue that with the Administrator's Order, along with the continued presence of Ruling 1739-R, the agency has still not acquiesced in the *Allina* decisions, and has issued the Administrator's Order and promulgated CMS Ruling 1739-R in furtherance of this non-acquiescence.[51] As such, this situation is what EJR was meant to address for the Providers.

Board's Decision and Analysis

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

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

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

The third issue is a challenge to the validity of the Administrator's Order that, if the Board finds jurisdiction, it "remand the cases to the appropriate [MAC] to recalculate the DSH payment adjustments for Part C patient days in accordance with the forthcoming new rule . . . ."

A. Board's Authority

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

The Board's analysis is detailed below.

B. Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[51] *Id*. at 26.

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[52, 53]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2013.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, the Providers were subject to the claim or protest requirements in 42 C.F.R. § 4051835(a)(1)(ii). However, the Administrator's Remand Order directs the Board to not apply that regulation, but rather apply the Secretary's acquiescence to the *Banner* decision as embodied in CMS Ruling 1727-R. CMS Ruling CMS-1727-R addresses dissatisfaction with the Medicare Contractor determinations and specifies that "assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought."[54]

In each of these cases, Part C days were either specifically adjusted, or filed under protest, and under the available directives in CMS Ruling 1727-R, the Board finds that the applicable Providers filed jurisdictionally valid appeals of the Part C days issue because the Providers are challenging the regulation governing treatment of Part C days in the DSH calculation and, thus, had "a good faith belief that the item [in this appeal] was subject to a payment regulation . . . that gave the MAC no authority or discretion to make payment in the manner the provider sought." Moreover, the appeals were timely filed and Board review of the matter at issue is not precluded by statute or regulation.

C. Medicare Part C Days Issue

The appeals involve the 2010 and 2011 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. For the time periods at issue in this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any

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[52] 42 C.F.R. § 405.1835(a).

[53] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

[54] CMS Ruling 1727-R at 2. Under ruling 1727-R, 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.

guidance on how the *vacatur* is being implemented (*e.g*., only circuit-wide versus nationwide).[55] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[56]

However, the Board hereby denies the EJR request relative to the Part C days issue because the Administrator's Order mandates that the Board remand the Providers if it finds jurisdiction over the Providers. Since the Board has found jurisdiction, the Board must remand and never has an opportunity to consider the merits of this cases, including but not limited to the Providers' EJR request. Accordingly, the Board will remand the Providers under separate cover.

D. Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[57]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[58] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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[55] *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[56] *See* 42 U.S.C. § 1395oo(f)(1).
[57] EJR Request at 17.
[58] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[59]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. However, the Administrator's Order makes clear that "Administrator Ruling 1739 does ***not apply*** to these judicially remanded claims and therefore also could not affect the Board's jurisdiction over these cases."[60] Accordingly, CMS Ruling 1727-R is not applicable in these cases and, accordingly, the Board denies the Providers EJR request challenging the validity of 1727-R.

E. Validity of the Administrator's Order

Finally, the Providers' challenge to the Administrator's Order is outside the scope of the regulation governing EJRs.

42 C.F.R. § 405.1842(a)(1) address the basis and scope of an EJR request:

> 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***).[61]

Thus, the lack of authority to decide the legal question then is described in § 405.1867 which states:

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[59] *See Southwest* at 6-7.
[60] Administrator's Order at 3 n. 2.
[61] (Emphasis added.)

> § 405.1867 *Scope of Board's legal authority*.
>
> In 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, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[62]

Significantly, § 405.1867 only lists authorities that are published for the general public and apply to all or certain classes of providers, namely statutes, regulations, and CMS Rulings. Here, the Providers are challenging the Administrator's Order (and not the authority by which it was issue, *i.e.*, § 405.1877) and the Order is not a statute, regulation or a CMS Ruling. Moreover, the Order was not issued to apply generally to providers or classes of providers. Rather, the Order was issued for a particular set of providers in specified cases pursuant to a regulation, § 405.1877(g)(2) (which again is not being challenged). Accordingly, the Board denies the EJR request challenging the Administrator's Order because it is beyond the scope of an EJR request. Rather, the Providers may have appeal rights relative to the Board's decision here and its application of the Administrator's Order, as appropriate and relevant, under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of the remanded providers within the instant group appeals, for the days *before* October 1, 2013, pursuant to CMS Ruling 1727-R;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to the directives of the Administrator's Remand Order, the Providers will receive a remand letter of this issue under separate cover;

3) The Board hereby **denies** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider. As indicated by the Administrator's ruling and Order, Ruling 1739-R is not implicated within this specific remand; and

[62] (Bold and underline emphasis added.)

4) The Board hereby denies EJR for the Providers for the limited question of the validity of the Administrator's Remand Order as that challenge is outside the scope of the EJR regulation.

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

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Dana Johnson, GBA C/O National Government Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Stephanie Webster, Esq.
Ropes & Gray, LLP
2099 Pennsylvania Ave NW
Washington, DC 20006

RE: ***Remand Letter***
14-4382G - Akin Gump 2010 SSI Fraction Medicare Advantage Days Group
14-4383G - Akin Gump 2010 Medicaid Fraction Medicare Advantage Days Group
15-2646G - Akin Gump 2011 Medicare Fraction Medicare Advantage Days Group
15-2647G - Akin Gump 2011 DSH Medicaid Fraction Medicare Advantage Days Grp.

Dear Ms. Webster:

The above-referenced group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

Pursuant to the June 3, 2022, CMS Administrator Order, responding to the Court's order in *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C), the Board reopened the above identified cases on July 27, 2022 for certain Providers remanded in those cases. The Administrator's Order directs the Board to determine whether it has jurisdiction over the remanded Providers, and if so, "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."[2]

On June 30, 2022, the Providers' Representative filed a Petition for EJR for the remaining providers remanded in the cases.[3] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. On August 17, 2022, the Board found that it had jurisdiction over the remanded Providers but denied the Providers' EJR request. The Board further noted that, consistent with the Administrator's Remand Order, it would proceed with the remand to the MAC.

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] CMS Administrator's Order, at 3 (emphasis added).
[3] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 14-4382G.

As it has jurisdiction over the providers remanded in the above-captioned cases, the Board hereby orders the following pursuant to the Administrator's Remand Order:

- The MAC shall 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).

The Board closes the group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

cc: Wilson Leong, FSS
Dana Johnson, National Government Services, Inc. (J-M)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Pkwy, Ste. 620
Plano, TX 75093

RE: ***Expedited Judicial Review Determination***
15-0041G - Southwest Consulting 2011 DSH SSI Fraction Part C Days Group II
15-0042G - Southwest Consulting 2011 DSH Medicaid Fraction Part C Days Group II
15-1749G - SWC 2012 DSH SSI Fraction Part C Days Group 2
15-1750G - SWC 2012 DSH Medicaid Fraction Part C Days Group 2

Dear Mr. Newell:

The Provider Reimbursement Review Board (Board) has reviewed the Providers' request for expedited judicial review (EJR) in the above-referenced appeals. The EJR request was filed on June 30, 2022.

In re: Allina II-Type DSH Adjustment Cases and the Administrator's Remand and Order

The above-referenced common issue related party ("CIRP") group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

In 2017, the Board granted EJR for the above referenced appeals, after concluding that it lacked jurisdiction over specific Providers/Fiscal Year Eds (FYE's) because those hospitals failed to claim or protest the Part C issue on their cost reports for periods ending on or after December 31, 2008.[2] The Board's jurisdictional dismissals relied on a now-superseded 2008 regulation, commonly known as the "self-disallowance regulation," which required for jurisdiction a hospital to have identified on its cost report as a protested item any claim for which it believed it was prevented by CMS policy from seeking reimbursement, provided there was not an audit adjustment related to that claim.[3]

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] Board's EJR Determination (Jul. 25, 2017), PRRB Case No. 13-2059G.
[3] *Id.*

In 2017 and 2018, the Providers in the above-captioned appeals filed complaints in the D.C. District Court challenging the Board's dismissal of their respective cases for lack of jurisdiction over the Part C issue.[4] In April 2018, the agency issued CMS Ruling 1727-R announcing that the agency would acquiesce in the *Banner* decision, and apply the court's holding in future cases. The Court consolidated the Providers' court actions into the following consolidated matter: *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C). On December 2, 2021, the Providers, among other hospitals, and the Secretary, submitted a joint status report requesting that the D.C. District Court vacate these Board jurisdictional dismissals made under the 2008 self-disallowance regulation and remand their cases to the Secretary. Four days later, the Court issued an order granting that request.

On June 3, 2022, the CMS Administrator issued an Order responding to the Court's order.[5] The Administrator remanded these cases to the Board and ordered that "the Board shall revisit the remanded cases, consistent with the court's order and the Secretary's acquiescence in [*Banner*]."[6] As noted in the footnote appended to this order, the Secretary's acquiescence is embodied in CMS Ruling 1727-R.[7]

The Administrator's Order further specifies that, in those instance where the Board determined "but for the 2008 self-disallowance regulation – it has jurisdiction, the [Board] 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."[8] Notably, consistent with the Court's Order, the 2008 self-disallowance regulation, 42 C.F.R. § 1835(a)(1)(ii) (2008), cannot be a basis for the Board to find it lacks jurisdiction.[9] Finally, the Administrator's Order specifies that that "[s]ince Administrator Ruling 1739 *does* ***not*** *apply* to these judicially remanded claims, *it also* ***cannot*** *be the basis for remanding* otherwise jurisdictionally proper claims to the MAC."[10]

The Administrator's Order directs that the Board's 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.[11]

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[4] *Id*.; *See Adcare Hospital et al. v. Becerra*, 17-cv-1896 (D.D.C.); *St. Mary's Health Care System et al. v. Becerra*, 17-cv-2106 (D.D.C.).
[5] CMS Administrator's Order (Jun. 3, 2022).
[6] *Id*. at 3 (footnote omitted).
[7] *Id.* at 3 n.1.
[8] *Id.* at 3.
[9] *Id*. at 3 n.2.
[10] *Id*. at 3 n.3 (emphasis added).
[11] *Id*.

EJR Request

On June 30, 2022, the Providers filed a Petition for EJR for the providers remanded in the referenced appeals, in the Administrator's Order.[12] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. The request for EJR was filed less than 30 days' after the Administrator's remand was issued, and before the Board was able to process the remand and reopen the appeals. On July 27, 2022, the Board reopened the four appeals addressed in this decision, as well as 27 other appeals. The Board *only* considered the EJR ripe for review ***as of the date the appeals were reopened*** and specified that, pursuant to 42 C.F.R. § 405.1842(b)(2), the 30-day period for review could not (and did not) begin until the Board had reopened the cases ***and*** finds jurisdiction over the remanded cases and underlying participants.

The Providers' request for Expedited Judicial Review ("EJR") of the "MAC's treatment of the Medicare Part C Days in the DSH calculation issue" and, thereby, challenged the Secretary's Part C days policy as adopted in the FY 2005 IPPS final rule.[13,14] The Providers further ask the Board to grant EJR despite the issuance of CMS Ruling 1739-R and, in turn, challenge the validity of said Ruling.[15] Finally, the EJR asserts that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions and, in turn, challenge the validity of the Administrator's Remand Order.[16] The Providers note that the Board is bound by the Part C days policy as adopted by final rule, Ruling 1739-R and the Administrator's Order and requests EJR relative to each of those authorities. The Board's decision to deny the Provider's EJR Request is set forth below.

Statutory and Regulatory Background

Medicare Advantage Program

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

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[12] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 13-2059GC.
[13] 69 Fed. Reg. 48,916, 49,099 (Aug. 11, 2004) (adopting the uncodified policy). The Secretary later codified this policy at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) (*i.e*., incorporated into the Code of Federal Regulations) as part of the FY 2008 IPPS final rule. *See* 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[14] *Id*, at 10
[15] *Id*, at 15.
[16] *Id*, at 2.

Inpatient hospital days for Medicare beneficiaries enrolled in HMOs and CMPs prior to 1999 are referred to as Medicare HMO patient care days.

In the September 4, 1990 Federal Register, the Secretary[17] stated that:

> Based on the language of section 1886(d)(5)(F)(vi) of the Act [42 U.S.C. § 1395ww(d)(5)(F)(vi)], which states that the disproportionate share adjustment computation should include "patients who were entitled to benefits under Part A," we believe it is appropriate to include the days associated with Medicare patients who receive care at a qualified HMO. Prior to December 1, 1987, we were not able to isolate the days of care associated with Medicare patients in HMOs, and therefore, were unable to fold this number into the calculation [of the DSH adjustment]. However, as of December 1, 1987, a field was included on the Medicare Provider Analysis and Review (MEDPAR) file that allows us to isolate those HMO days that were associated with Medicare patients. Therefore, since that time we have been including HMO days in the SSI/Medicare percentage [of the DSH adjustment].[18]

At that time, Medicare Part A paid for HMO services and patients continued to be eligible for Part A.[19]

With the creation of Medicare Part C in 1997,[20] Medicare beneficiaries who opted for managed care coverage under Medicare Part C were no longer entitled to have payment made for their care under Part A. Consistent with the statutory change, CMS did not include Medicare Part C days in the SSI ratios used by the Medicare contractors to calculate DSH payments for the fiscal years 2001-2004.[21]

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

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[17] of Health and Human Services.
[18] 55 Fed. Reg. 35990, 39994 (Sept. 4, 1990).
[19] *Id.*
[20] The Medicare Part C program did not begin operating until January 1, 1999. *See* P.L. 105-33, 1997 HR 2015, *codified as* 42 U.S.C. § 1394w-21 Note (c) "Enrollment Transition Rule.- An individual who is enrolled [in Medicare] on December 31 1998, with an eligible organization under . . . [42 U.S.C. 1395mm] shall be considered to be enrolled with that organization on January 1, 1999, under part C of Title XVIII . . . if that organization as a contract under that part for providing services on January 1, 1999 . . . ." This was also known as Medicare+Choice. The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub.L. 108-173), enacted on December 8, 2003, replaced the Medicare+Choice program with the new Medicare Advantage program under Part C of Title XVIII.
[21] 69 Fed. Reg. 48918, 49099 (Aug. 11, 2004).

> . . . once a beneficiary has elected to join an M+C plan, that beneficiary's benefits are no longer administered under Part A . . . . *once a beneficiary elects Medicare Part C, those patient days attributable to the beneficiary should not be included in the Medicare fraction of the DSH patient percentage. These patient days should be included in the count of total patient days in the Medicaid fraction (the denominator), and the patient's days for the M+C beneficiary who is also eligible for Medicaid would be included in the numerator of the Medicaid fraction . . . .*[22]

The Secretary purportedly changed her position in the Federal fiscal year ("FFY") 2005 IPPS final rule, by noting she was "revising our regulations at [42 C.F.R.] § 412.106(b)(2)(i) to include the days associated with [Part C] beneficiaries in the Medicare fraction of the DSH calculation."[23] In response to a comment regarding this change, the Secretary explained that:

> . . . *We do agree that once Medicare beneficiaries elect Medicare Part C coverage, they are still, in some sense, entitled to benefits under Medicare Part A*. We agree with the commenter that these days should be included in the Medicare fraction of the DSH calculation. Therefore, we are *not adopting as final our proposal stated in the May 19, 2003 proposed rule to include the days associated with M+C beneficiaries in the Medicaid fraction. Instead, we are adopting a policy to include the patient days for M+C beneficiaries in the Medicare fraction* . . . . if the beneficiary is also an SSI recipient, the patient days will be included in the numerator of the Medicare fraction. We are revising our regulations at § 412.106(b)(2)(i) to include the days associated with M+C beneficiaries in the Medicare fraction of the DSH calculation.[24]

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

Although the change in DSH policy regarding 42 C.F.R. § 412.106(b)(2)(i) was included in the August 11, 2004 Federal Register, no change to the regulatory language was published until August 22, 2007, when the FFY 2008 IPPS final rule was issued.[25] In that publication, the Secretary noted that no regulatory change had in fact occurred, and announced that she had made "technical corrections" to the regulatory language consistent with the change adopted in the FFY 2005 IPPS final rule. These "technical corrections" are reflected at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B).[26] As a result of these rulemakings, Part C days were

[22] 68 Fed. Reg. 27154, 27208 (May 19, 2003) (emphasis added).
[23] 69 Fed. Reg. at 49099.
[24] *Id.* (emphasis added).
[25] 72 Fed. Reg. 47130, 47384 (Aug. 22, 2007).
[26] *Id*. at 47411.

required to be included in the Medicare fraction as of October 1, 2004 (the "Part C DSH policy"). Subsequently, as part of the FFY 2011 IPPS final rule published on August 15, 2010, CMS made a minor revision to §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) "to clarify" the Part C DSH policy by replacing the word "or" with "including."[27]

The U.S. Circuit Court for the District of Columbia in *Allina Healthcare Services v. Sebelius* ("*Allina I*"),[28] vacated both the FFY 2005 IPPS final rule adopting the Part C DSH policy and the subsequent regulations issued in the FFY 2008 IPPS final rule codifying the Part C DSH policy adopted in FFY 2005 IPPS rule.[29] In *Allina Health Services v. Price* ("*Allina II*"),[30] the D.C. Circuit confirmed that the Secretary's 2004 attempt to change the standard to include Part C days in the Medicare fraction had been vacated in *Allina I*.[31] The D.C. Circuit further found in *Allina II* that the Secretary failed to provide proper notice and comment before including Part C days in the Medicare fractions published for FY 2012.[32] Most recently, the Supreme Court affirmed the D.C. Circuit Court's judgment in *Allina II*.[33]

CMS Ruling 1739-R

On August 17, 2020, in response to the *Allina* decisions, CMS issued ruling 1739-R (the "Ruling"). The Ruling states that the Board, and other Medicare administrative appeals tribunals, lack jurisdiction over certain provider appeals. The appeals subject to the Ruling involve the treatment of certain patient days, associated with patients enrolled in Medicare Advantage plans, in the Medicare and Medicaid fractions of the disproportionate patient percentage. The Ruling applies only to appeals that: (1) concern patient days with discharge dates before October 1, 2013; and (2) arise from Notices of Program Reimbursement ("NPR") issued before CMS issues a new final rule to govern the treatment of patient days with discharge dates before October 1, 2013. The Ruling also applies to appeals based on an untimely NPR under 42 U.S.C. § 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for a fiscal year that pre-dates the new final rule.[34] Further, the Ruling requires that the Board remand any otherwise jurisdictionally proper challenge raising this issue to the appropriate Medicare contractor.[35] The

[27] 75 Fed. Reg. 50042, 50285-50286, 50414 (Aug. 16, 2010). *See also* 75 Fed. Reg. 23852, 24006-24007 (May 4, 2010) (preamble to proposed rulemaking stating: "We are aware that there might be some confusion about our policy to include MA days in the SSI fraction. . . . In order to further clarify our policy that patient days associated with MA beneficiaries are to be included in the SSI fraction because they are still entitled to benefits under Medicare Part A, we are proposing to replace the word 'or' with the word 'including' in § 412.106(b)(2)(i)(B) and § 412.106(b)(2)(iii)(B)."); *Allina Healthcare Servs. v. Sebelius*, 904 F. Supp. 2d 75, 82 n.5, 95 (2012), *aff'd in part and rev'd in part*, 746 F. 3d 1102 (D.C. Cir. 2014).
[28] 746 F. 3d 1102 (D.C. Cir. 2014).
[29] *Id*. at 1106 n.3, 1111 (affirming portion of the district court decision vacating the FFY 2005 IPPS rule). *See also Allina Health Servs. v. Sebelius*, 904 F. Supp. 2d 75, 89 (D.D.C. 2012) ("The Court concludes that the Secretary's interpretation of the fractions in the DSH calculation, announced in 2004 and not added to the Code of Federal Regulations until the summer of 2007, was not a "logical outgrowth" of the 2003 NPRM.").
[30] 863 F.3d 937 (D.C. Cir. 2017).
[31] *Id.* at 943.
[32] Id. at 943-945.
[33] *Azar v. Allina Health Services*, 139 S. Ct. 1804 (June 3, 2019).
[34] CMS Ruling 1739-R (Aug. 17, 2020).
[35] *Id*.

Ruling explains that Medicare contractors will then calculate the provider's DSH payment adjustment pursuant to the forthcoming final rule.[36]

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

> In many such cases [Part C Days in the SSI/Medicare Fraction], the PRRB has granted expedited judicial review (EJR). After the Supreme Court's decision, the United States District Court for the District of Columbia granted the Secretary's motion to consolidate most of these cases (in re: Allina II-Type DSH Adjustment Cases, 19-mc-190). Prior to consolidation, many such cases had been stayed pending the outcome of the Allina proceedings. The Secretary has since moved for a voluntary remand of these consolidated cases so that he can re-examine the claims in light of the Supreme Court's decision and take further action as necessary to comply with the applicable legal standards announced therein. The Secretary has determined that he has no choice but to engage in a new rulemaking to resolve the issue.
>
> Although the Supreme Court has resolved the legal issue, the PRRB has continued to grant EJR to appeals presenting Allina-type claims. By this Ruling, the Administrator provides notice that the PRRB and other Medicare administrative appeals tribunals lack jurisdiction over the Part C days issue for years before FY 2014 as to any appeals arising from NPRs from that period that pre-dates the forthcoming rule or that arise from an appeal based on an untimely NPR under 42 U.S.C. 1395oo(a)(1)(B) or (C) and any subsequently issued NPR for that fiscal year pre-dates the new final rule. The Supreme Court has made it clear that Medicare fractions and DSH payments in all Allina-like cases must be recalculated pursuant to a properly promulgated regulation. It will conserve administrative and judicial resources to remand qualifying appeals in recognition of controlling Supreme Court precedent instead of suits continuing to be filed and consolidated in federal district court, followed by the Secretary seeking remand for further proceedings consistent with the Supreme Court's decision. Instead, under this Ruling, the pertinent administrative appeals tribunal must remand each qualifying appeal to the appropriate Medicare contractor. CMS and the Medicare contractors will calculate DSH payment adjustments on remand in accordance with CMS's forthcoming rule.[37]

[36] *Id*.
[37] CMS Ruling 1739-R at 6-7.

Provider's Request for EJR

The Providers within the CIRP group appeals are challenging their Medicare reimbursement for the fiscal years 2011 and 2012 cost reporting periods. The Providers state that they "have been expecting that Medicare Part C days would be appropriately treated in their DSH calculations following the decisions in *Allina I* and *Allina II*."[38] The Providers further assert that, despite the federal court rulings in these cases, their respective DSH payment determinations remain "uncorrected" as these payment calculations were based on the "now-vacated [2004] rule."[39] The Providers argue that, under the applicable regulations, the Board is bound to apply the vacated 2004 rule that the Secretary has "left on the books."[40] As such, the Providers conclude that the Board is "required" to grant EJR.[41]

The Providers argue that the Board has jurisdiction but lacks authority to grant relief over the issue raised in this appeal, namely, "the substantive and procedural validity of the continued application of the vacated 2004 rule in the DSH payment determinations at issue."[42] The Providers disagree with CMS' instruction to the Board to remand this appeal, and argue that a remand is counter to the providers' right to appeal to federal court as set forth in 42 U.S.C. § 1395oo. The Providers conclude that EJR is appropriate because "the agency has still not acquiesced in the *Allina* decisions . . ."[43]

The Providers also argue that:

> CMS Ruling 1739-R by its own terms does not deprive the Board of the ability to determine that it has jurisdiction over these Providers' DSH Part C appeals and could not do so without violating provisions of the Medicare statute that are binding on the Board here.[44]
>
> First, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals. This approach is consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction, which the Ruling itself acknowledges. *See* CMS Ruling 1739-R at 7 (requiring that the Board determine whether an appeal "satisfies the applicable jurisdictional and procedural requirements"). This is a straightforward application of the familiar principle that the Board routinely applies in exercising jurisdiction to determine its jurisdiction. "[I]t is familiar law that a federal court always has

[38] EJR Request at 1.
[39] *Id*. at 1.
[40] *Id*.
[41] *Id*. at 1-2.
[42] *Id*. at 11-12.
[43] *Id*. at 21.
[44] *Id*. at 14.

> jurisdiction to determine its own jurisdiction." *U.S. v. Ruiz*, 536 U.S. 622, 627 (2002).[45]
>
> . . . .
>
> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[46]

Further, the Providers argue that a final adoption of the Administrator's remand order would render the pending appeals as "moot" by directing the Board to essentially follow ruling 1739-R without any ability for the Board to determine its authority to decide legal questions.[47] They add:

> The CMS Administrator's June 3, 2022, order ("Administrator's Order") similarly and improperly treats the Providers' appeals as moot by directing the Board to remand those cost years that are jurisdictionally proper to the MAC for recalculation of the DSH payment adjustment in accordance with the forthcoming final Part C rule. However, the Administrator's Order and the August 2020 CMS Ruling 1739-R both call for the Board to determine its jurisdiction over Part C appeals, and do not and cannot override the Board's obligation to make determinations as to its authority to decide legal questions.[48]

The Providers assert that like the Administrator's Order, the Ruling expressly directs the Board to determine its jurisdiction over pending Part C appeals.[49] They argue that this approach is again consistent with the accepted premise that the Board always has the ability to determine if it has jurisdiction. While the Ruling explains in its discussion of Board jurisdiction that the Board has been granting EJR for Part C appeals, as required by the Medicare statute and regulations, it does not direct any specific action by the Board on such EJR requests, or attempt to relieve the Board of its mandatory statutory and regulatory obligation to make EJR determinations.[50]

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[45] *Id*. at 14.
[46] *Id.* at 17.
[47] Providers' Petition for Expedited Judicial Review, at 2.
[48] *Id*.
[49] *Id*. at 20.
[50] *Id*. at 20-21.

They argue that with the Administrator's Order, along with the continued presence of Ruling 1739-R, the agency has still not acquiesced in the *Allina* decisions, and has issued the Administrator's Order and promulgated CMS Ruling 1739-R in furtherance of this non-acquiescence.[51] As such, this situation is what EJR was meant to address for the Providers.

Board's Decision and Analysis

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

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

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

The third issue is a challenge to the validity of the Administrator's Order that, if the Board finds jurisdiction, it "remand the cases to the appropriate [MAC] to recalculate the DSH payment adjustments for Part C patient days in accordance with the forthcoming new rule . . . ."

A. Board's Authority

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

The Board's analysis is detailed below.

B. Jurisdictional Requirements for Providers

The Board's analysis begins with the question of whether it has jurisdiction to conduct a hearing on the specific matter at issue for each of the Providers requesting EJR. A provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is

[51] *Id*. at 26.

dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more for an individual appeal or $50,000 or more for a group, and the request for hearing was timely filed.[52, 53]

The Providers included in the instant EJR requests filed appeals of original Notices of Program Reimbursement ("NPRs") in which the Medicare contractor settled cost reporting periods ending in 2013.

For Providers with appeals filed from original NPRs for cost reporting periods ending on December 31, 2008 and which began before January 1, 2016, the Providers were subject to the claim or protest requirements in 42 C.F.R. § 4051835(a)(1)(ii). However, the Administrator's Remand Order directs the Board to not apply that regulation, but rather apply the Secretary's acquiescence to the *Banner* decision as embodied in CMS Ruling 1727-R. CMS Ruling CMS-1727-R addresses dissatisfaction with the Medicare Contractor determinations and specifies that "assuming all other applicable jurisdictional requirements are met, a provider has a right to a Medicare Administrative Contractor (MAC) hearing or a Provider Reimbursement Review Board (PRRB) hearing for an item the provider did not include on its cost report due to a good faith belief that the item was subject to a payment regulation or other policy that gave the MAC no authority or discretion to make payment in the manner the provider sought."[54]

In each of these cases, Part C days were either specifically adjusted, or filed under protest, and under the available directives in CMS Ruling 1727-R, the Board finds that the applicable Providers filed jurisdictionally valid appeals of the Part C days issue because the Providers are challenging the regulation governing treatment of Part C days in the DSH calculation and, thus, had "a good faith belief that the item [in this appeal] was subject to a payment regulation . . . that gave the MAC no authority or discretion to make payment in the manner the provider sought." Moreover, the appeals were timely filed and Board review of the matter at issue is not precluded by statute or regulation.

C. Medicare Part C Days Issue

The appeals involve the 2011 and 2012 cost reporting periods. Thus, the appealed cost reporting periods fall squarely within the time frame applicable to the Secretary's Part C DSH policy being challenged which was adopted in the FFY 2005 IPPS final rule and later codified at 42 C.F.R. §§ 412.106(b)(2)(i)(B) and (b)(2)(iii)(B) as part of the FY 2008 IPPS final rule. For the time periods at issue in this request, the D.C. Circuit in *Allina I* vacated this regulation. However, the Secretary has not formally acquiesced to that *vacatur* and, in this regard, has not published any

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[52] 42 C.F.R. § 405.1835(a).

[53] For appeals filed on or after August 21, 2008, a hearing request is considered timely if it is filed within 180 days of the date of receipt of the final determination. 42 C.F.R. § 405.1835(a) (2008).

[54] CMS Ruling 1727-R at 2. Under ruling 1727-R, 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.

guidance on how the *vacatur* is being implemented (*e.g*., only circuit-wide versus nationwide).[55] Moreover, the D.C. Circuit is the only circuit to date that has vacated the regulation and, if the Board were to grant EJR, the Providers would have the right to bring suit in either the D.C. Circuit *or* the circuit within which they are located.[56]

However, the Board hereby denies the EJR request relative to the Part C days issue because the Administrator's Order mandates that the Board remand the Providers if it finds jurisdiction over the Providers. Since the Board has found jurisdiction, the Board must remand and never has an opportunity to consider the merits of this cases, including but not limited to the Providers' EJR request. Accordingly, the Board will remand the Providers under separate cover.

D. Validity of CMS Ruling 1739-R

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

> Section 1395oo(a) [of the Social Security Act] grants the Board jurisdiction over each of the DSH Part C group appeals at issue here. . . . [T]he Providers have submitted schedules of providers in each group appeal and supporting documentation that establish their satisfaction of the requirements for a hearing in section 1395oo(a). Congress granted the Board the subject-matter jurisdiction conferred by section 1395oo(a). Nothing in that section or any other statute authorizes the Secretary to divest the Board of subject-matter jurisdiction conferred to it by section 1395oo(a). CMS's attempt to do this via the Ruling violates the statute's grant of providers' substantive appeal rights and is invalid.[57]

The Board notes that it has previously been presented with, and considered, a similar argument within PRRB Dec. No. 2010-D36, *Southwest Consulting 2004 DSH Dual Eligible Days Group, et al. v. Blue Cross Blue Shield Ass'n*, PRRB Dec. No. 2010-D36 (June 14, 2010),[58] in which the providers challenged the validity of CMS Ruling CMS-1498-R. In its *Southwest* decision, the Board observed the following:

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[55] *See generally Grant Med. Ctr. v. Burwell,* 204 F. Supp. 3d 68, 77-82 (D.D.C. 2016), *aff'd*, 875 F.3d 701 (D.C. Cir. 2017).
[56] *See* 42 U.S.C. § 1395oo(f)(1).
[57] EJR Request at 17.
[58] In *Southwest*, the Board considered whether it should grant the providers' request for EJR over the validity of the provisions of CMS Ruling 1498-R which, if valid, render moot and deny jurisdiction over the dual-eligible group appeals. The Board found that EJR was appropriate because the providers' appeals were properly pending before the Board as CMS 1498-R required the Board to determine whether the appeals satisfied the applicable jurisdictional and procedural requirements of section 1878 of the Act, but the Board lacked the authority to determine whether the Ruling deprived it of continuing jurisdiction. The Board's decision in *Southwest* was ultimately vacated by the Administrator. *See Southwest Consulting 2004 DSH Dual Eligible Days Grp., et al. v. Blue Cross Blue Shield Ass'n*, Adm'r Dec. (Aug. 12, 2010), *vacating and remanding*, PRRB Dec. No. 2010-D36 (June 14, 2010).

> The problem presented in this dispute is unique because the jurisdiction question arises only because the Ruling, which has been challenged as being invalid, is what purports to deprive the Board of jurisdiction it previously had over these appeals. But for the Ruling's provision divesting the Board of jurisdiction, there is no dispute that the Board has jurisdiction and would have authority to grant EJR pursuant to the Providers' challenge as to the other substantive provisions of the Ruling. The Board's dilemma in resolving the jurisdiction question is that the Ruling's provisions that purport to divest the Board of jurisdiction are inextricably intertwined with the substantive provisions of the Ruling challenged as being contrary to law and which the Board has no authority to invalidate.[59]

Here, as in *Southwest*, the Board finds that it does not have authority to consider the validity of CMS Ruling CMS 1739-R. However, the Administrator's Order makes clear that "Administrator Ruling 1739 does ***not apply*** to these judicially remanded claims and therefore also could not affect the Board's jurisdiction over these cases."[60] Accordingly, CMS Ruling 1727-R is not applicable in these cases and, accordingly, the Board denies the Providers EJR request challenging the validity of 1727-R.

E. Validity of the Administrator's Order

Finally, the Providers' challenge to the Administrator's Order is outside the scope of the regulation governing EJRs.

42 C.F.R. § 405.1842(a)(1) address the basis and scope of an EJR request:

> 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***).[61]

Thus, the lack of authority to decide the legal question then is described in § 405.1867 which states:

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[59] *See Southwest* at 6-7.
[60] Administrator's Order at 3 n. 2.
[61] (Emphasis added.)

> § 405.1867 *Scope of Board's legal authority*.
>
> In 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, as well as CMS Rulings issued under the authority of the Administrator as described in § 401.108 of this subchapter. The Board shall afford great weight to interpretive rules, general statements of policy, and rules of agency organization, procedure, or practice established by CMS.[62]

Significantly, § 405.1867 only lists authorities that are published for the general public and apply to all or certain classes of providers, namely statutes, regulations, and CMS Rulings. Here, the Providers are challenging the Administrator's Order (and not the authority by which it was issue, *i.e.*, § 405.1877) and the Order is not a statute, regulation or a CMS Ruling. Moreover, the Order was not issued to apply generally to providers or classes of providers. Rather, the Order was issued for a particular set of providers in specified cases pursuant to a regulation, § 405.1877(g)(2) (which again is not being challenged). Accordingly, the Board denies the EJR request challenging the Administrator's Order because it is beyond the scope of an EJR request. Rather, the Providers may have appeal rights relative to the Board's decision here and its application of the Administrator's Order, as appropriate and relevant, under the provisions of 42 U.S.C. § 1395oo(f)(1) and 42 C.F.R. §§ 405.1875 and 405.1877.

Conclusion

1) The Board finds it has jurisdiction to hear the appeals of the remanded providers within the instant group appeals, for the days *before* October 1, 2013, pursuant to CMS Ruling 1727-R;

2) The Board hereby **denies** Providers' EJR Request regarding the substantive and procedural validity of the continued application of the vacated 2004 rule with respect to the treatment of Medicare Part C Days in the DSH payment determinations. Rather, pursuant to the directives of the Administrator's Remand Order, the Providers will receive a remand letter of this issue under separate cover;

3) The Board hereby **denies** EJR for the Providers for the limited question of the validity of the provision of CMS Ruling CMS 1739-R that divests the Board of substantive jurisdiction over the Medicare Part C Days issue that, *but for the Ruling*, the Board has the authority to consider. As indicated by the Administrator's ruling and Order, Ruling 1739-R is not implicated within this specific remand; and

[62] (Bold and underline emphasis added.)

4) The Board hereby denies EJR for the Providers for the limited question of the validity of the Administrator's Remand Order as that challenge is outside the scope of the EJR regulation.

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

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Michael Newell
Southwest Consulting Associates
2805 North Dallas Pkwy, Ste. 620
Plano, TX 75093

RE: ***Remand Letter***
15-0041G - Southwest Consulting 2011 DSH SSI Fraction Part C Days Group II
15-0042G - Southwest Consulting 2011 DSH Medicaid Fraction Part C Days Grp. II
15-1749G - SWC 2012 DSH SSI Fraction Part C Days Group 2
15-1750G - SWC 2012 DSH Medicaid Fraction Part C Days Group 2

Dear Mr. Newell:

The above-referenced group appeals[1] include a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013.

Pursuant to the June 3, 2022, CMS Administrator Order, responding to the Court's order in *In re: Allina II-Type DSH Adjustment Cases*, 19-mc-190 (D.D.C), the Board reopened the above identified cases on July 27, 2022 for certain Providers remanded in those cases. The Administrator's Order directs the Board to determine whether it has jurisdiction over the remanded Providers, and if so, "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."[2]

On June 30, 2022, the Providers' Representative filed a Petition for EJR for the remaining providers remanded in the cases.[3] The applicable providers and cost report years for these appeals include those attached in the schedule of providers at **Attachment A**. On August 17, 2022, the Board found that it had jurisdiction over the remanded Providers but denied the Providers' EJR request. The Board further noted that, consistent with the Administrator's Remand Order, it would proceed with the remand to the MAC.

[1] 42 C.F.R. § 405.1837(b)(1) (mandating use of groups by related providers for common issues).
[2] CMS Administrator's Order, at 3 (emphasis added).
[3] Providers' Petition for Expedited Judicial Review (Jun. 30, 2022), PRRB Case no. 15-0041GC.

As it has jurisdiction over the providers remanded in the above-captioned cases, the Board hereby orders the following pursuant to the Administrator's Remand Order:

- The MAC shall 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).

The Board closes the group cases and removes them from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/17/2022

X Clayton J. Nix

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

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

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

Danelle Decker
National Government Services, Inc.
Mail point INA102-AF42
P.O. Box 6474
Indianapolis, IN 46206

RE: ***Jurisdictional Determination***
Danbury Hospital
FYE 09/30/2014
Case No. 17-2097

Dear Mr. Ravindran and Ms. Decker,

The Provider Reimbursement Review Board (the "Board") has reviewed jurisdiction in response to the Medicare Contractor's jurisdictional challenge in the above-referenced appeal. The Board's jurisdictional decision is set forth below.

Background:

The Provider submitted a request for hearing on August 15, 2017, based on a Notice of Program Reimbursement ("NPR") dated February 22, 2017. The hearing request included 12 issues as follows:

- Issue 1 – Whether the Medicare Administrative Contractor ("MAC") used the correct Supplemental Security Income ("SSI") percentage in the Disproportionate Share Hospital ("DSH") calculation.[1]
- Issue 2 – Whether the Medicare/SSI fraction used in the Medicare DSH and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per the Medicare Statute at 42 U.S.C. §1395ww(d)(5)(F)(vi)?
- Issue 3 – Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") Days were properly accounted for in the DSH calculation.[2]
- Issue 4 – Whether patient days associated with Medicare Part A and Title XIX eligible patients should be excluded from the SSI or Medicare fraction of the Medicare 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 a payment.[3]

[1] On July 26, 2022, this issue was withdrawn.
[2] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1257G.
[3] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1259G.

- Issue 5 – Whether HMO / Medicare Plus Choice / Medicare Managed Care / Medicare Part C / Medicare Advantage ("MA") were properly accounted for in the DSH calculation.[4]
- Issue 6 – Whether patient days associated with Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare DSH calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[5]
- Issue 7 – Whether the MAC properly excluded Medicaid eligible days from the DSH calculation.[6]
- Issue 8 – Whether Medicare Managed Care / Medicare Part C Days were properly accounted for in the DSH calculation.[7]
- Issue 9 – Whether patient days association Medicare Part A and Title XIX eligible patients should be included in the Medicaid percentage of the Medicare DSH calculation. Further, whether the MAC should have included in the Medicaid fraction of the DSH calculation patient days applicable to patients who were eligible for both Medicare and Medicaid where Medicare Part A did not make a payment.[8]
- Issue 10 – Whether the provision in the Fiscal Year 2014 Inpatient Prospective Payment System ("IPPS") Final Rule that imposes a .2 percent decrease in the IPPS rates for all IPPS hospitals for each of FYs 2014 – 2018 is procedurally invalid, arbitrary and capricious, and outside the statutory authority of the Centers for Medicare & Medicaid Services ("CMS").[9]
- Issue 11 – The issue in this appeal involves CMS's calculations of the pool of uncompensated care ("UCC") payments available for distributions to DSH eligible hospitals (i.e., the UCC Distribution Pool issue) as finalized in the 2014 IPPS rulemaking on August 2, 2013.[10]
- Issue 12 – Whether the Secretary was arbitrary and capricious in allowing 1115 waiver patient days to be included in the Provider's DSH Medicaid fraction, while at the same time refusing to allow patient days covered through Medicaid DSH programs. The MAC acted improperly in failing to included inpatient days attributable to patients eligible for medical assistance under Connecticut State Administered General Assistance ("SAGA") in the computation of the Medicaid fraction for the Medicare DSH adjustment as required by statute and by 42 C.R.R. § 412.106(b)(2)(i). Has the Secretary violated the equal

[4] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1258G.
[5] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1260G.
[6] On March 10, 2022, this issue was withdrawn.
[7] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1258G.
[8] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1260G.
[9] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1256G.
[10] On April 30, 2018, this issue was transferred to PRRB Case No. 18-1261G.

> protection clause in the constitution by treating similarly situated providers in different States differently?[11]

After transfers and withdrawals, Issue 2 - DSH/SSI – Systemic Errors is the ***only*** remaining issue in the instant appeal.

In its initial appeal request, the Provider refers to Issue 2 in short as the "SSI Percentage (Systemic Errors)" issue and describes Issue 2 as "[w]hether the Medicare/SSI Fraction used in the Medicare [DSH] and LIP payment calculations accurately and correctly counted the correct number of patient days to be included in the numerator and denominator of the Medicare/SSI fraction calculation per . . . 42 U.S.C. § 1395ww(d)(F)(vi)." The appeal request then explains Issue 2 as follows:

> The Provider contends that the Lead MAC's determination of Medicare Reimbursement for their DSH Payments are not in accordance with the Medicare statute 42 U.S.C. § l395ww (d)(5)(F)(vi). The Provider contends that the 551 percentages calculated by [CMS] and used by the Lead MAC to settle their cost Report were incorrectly computed.
>
> The Provider also contends that CMS inconsistently interprets the term "entitled" as it is used in the statute. CMS requires S SI payment for days to be counted in the numerator but does not require Medicare Part A payment for days to be counted in the denominator. CMS interprets the term "entitled" broadly as it applies to the denominator by including patient days of individuals that are in some sense "eligible" for Medicare Part A (i.e. Medicare Part C, Medicare Secondary Payer and Exhausted days of care) as Medicare Part A days, yet refuses to include patient days associated with individuals that were "eligible" for SSI but did not receive an SSI payment.
>
> The Provider further contends that the SSI percentages calculated by [CMS] fail to address all the deficiencies as described in *Baystate Medical Center v. Michael 0. Leavitt*, 545 F. Supp. 2d 20, as amended, 587 F. Supp. 2d 37, 44 (D.D.C. 2008) and incorporate a new methodology inconsistent with the Medicare Statute. Providers in this case are also seeking resolution of the following additional aspects of the Medicare fraction that were not addressed in the Baystate case:
>
> 1. Availability of MEDPAR and SSA records,
> 2. Failure to adhere to required notice and comment rulemaking procedures,
> 3. Fundamental problems in the SSI percentage calculation,
> 4. Not in agreement with provider's records,
> 5. Paid days vs. Eligible Days, and

[11] On April 30, 2018, this issue was transferred to PRRB Case No. 18-0598G.

6. Covered days vs. Total days.[12]

In calculating the estimated impact of Issue 2 referred to the "SSI Percentage (Systemic Errors)," the Provider simple estimated a 0.25 percent increase in the SSI percentage, resulting in an amount in controversy ("AiC") of $147,597 for Issue 2. Significantly, the Provider did not explain why or how it arrived at the 0.25 percent used in calculating the AiC for Issue 2. Indeed, without explanation, the Provider indiscriminately uses the 0.25 percent for estimating the impact of Issues 1 through 4.

On August 25, 217, the Board issued Notice of Case Acknowledgment and Critical Due Date setting deadlines for the parties to file preliminary position papers. On April 27, 2018, the Provider filed its preliminary position paper.

On July 3, 2018, FSS filed a jurisdictional challenge on behalf of the Medicare Contractor. Pursuant to Board Rule 44.4 (July 2015), the Provider's response was due within 30 day. On July 12, 2018, Quality Reimbursement Services ("QRS") filed a response to the jurisdictional challenge *allegedly* on behalf of the Provider. However, that filing did not include a change of representative letter executed by the Provider in compliance with Board Rule 5 was ***improper*** and cannot be considered *because QRS was* ***not*** *the authorized representative* and, hence, not authorized under Board Rule 5 to file that response. The case file reflects that the authorized representative remained Jen Zupcoe at Danbury Hospital at that time.

On December 10, 2021, the Board issued the Notice of Hearing and Critical Due Dates to Ms. Zucoe. This Notice set the hearing date of August 25, 2022 and the deadlines of May 27, 2022 for the Provider's final position paper, June 26, 2022 for the Medicare Contractor's final position paper, and July 26, 2022 for the Provider's (Optional) Responsive brief. This Notice also included the following instruction on the Provider's final position paper:

> For each remaining issue, the position paper **must state** the material facts that support the appealed claim, **identify the controlling authority** (e.g., statutes, regulations, policy, or **case law**), and provide arguments applying the material facts to the controlling authorities. **This filing must also include any exhibits the Provider will use to support its position**. *See* Board Rule 27 for more specific content requirements. If the Provider misses its due date, the Board will dismiss the cases.[13]

On March 9, 2022, QRS filed a change of representative letter from the Provider dated March 9, 2022. Thus, as of March 9, 2022, QRS became the authorized representative in this case. This reinforces the fact that 3.5+ years earlier, QRS was not authorized under Board Rules to file the July 12, 2018 response to the jurisdictional challenge.

On May 26, 2022, QRS filed the Provider's final position paper. On June 21, 2022, FSS filed the Medicare Contractor's final position paper.

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[12] Issue Statement at 2 (Aug. 15, 2017).
[13] (Footnote omitted and bold and underline emphasis added.)

On August 10, 2022, QRS filed a request that the Board postpone the hearing scheduled for August 25, 2022 "pending the final outcome of *Pomona Valley Hospital Med v. Xavier Becerra*, 20-5250 (Attached) in the United States Court of Appeals for District of Columbia Circuit." In making this request, QRS alleged that "[t]he Pomona Valley Hospital case deals with *substantially similar issues* to those addressed in PRRB Case Number 17-2097 namely the providers challenged the inaccuracy of the SSI Percentage."[14]

Medicare Contractor's Jurisdictional Challenge:

The Board received a Jurisdictional Challenge filed on behalf of the MAC on July 3, 2018. The MAC contends that the Board does not have jurisdiction over portions of the SSI – Systemic Errors issue because the Medicare Advantage Days issue and Dual Eligible Days issues are separate and distinct issues that must be separately appealed.[15] The MAC also notes that the Provider is a participant in the following *optional* group appeals, thereby improperly duplicating parts of the issue that QRS maintains in the Provider's Final Position Paper remain in the appeal:

- Group #18-1257G, QRS 2014 DSH SSI Fraction Medicare Managed Care Part C Days Group 2
- Group #18-1258G, QRS 2014 DSH Medicaid Fraction Medicare Managed Care Part C Days Group 2
- Group #18-1259G, QRS 2014 DSH SSI Fraction Dual Eligible Days Group 2
- Group #18-1260G, QRS 2014 DSH Medicaid Fraction Dual Eligible Days Group 2[16]

Jurisdictional Response *Improperly* Filed By QRS:

As previously explained above, on July 12, 2018, QRS ***improperly*** filed an *alleged* response of the Provider to the MAC's July 3, 2018, Jurisdictional Challenge. QRS argued that "the SSI Systemic issue" addresses the various factor which lead to inaccurate SSI percentages calculated by CMS as well as the deficiencies as described in *Baystate Medical Center v. Leavitt*, 545 F. Supp. 2d 20, as amended 587 F. Supp. 2d 37, 44 (D.D.C. 2008).[17] QRS goes on to contend that the transferred issues deal with more narrow issues, while the SSI Systemic issue specifically represents different aspects/components of the SSI issue from the SSI Dual Eligible issue and SSI Part C Days issue, and thereby complies with Board Rule 8.1.[18]

[14] (Emphasis added.)
[15] MAC's Jurisdictional Challenge at 3 (July 3, 2018). *See also* 42 C.F.R. § 405.1837(a)(2) and Board Rule 8.1.
[16] *Id*. at 4.
[17] Provider's Jurisdictional Response at 1 (July 12, 2018).
[18] *Id*. at 1-2.

Provider's Final Position Paper:

On May 26, 2022, QRS filed the Provider's Final Position Paper and this filing was proper as QRS was the authorized representative in this case as of March 9, 2022. Significantly, the filing was NOT for Case No. 17-2097. Rather, per the cover letter, the caption for the final position paper itself, and the statement of the facts (including the fact on the Medicaid eligible days issue), it was for Case No. 16-0871, Danbury's appeal of its FY 2012 cost report.

Even if the position paper was for Case No. 17-2097, there are problems with the filing. As explained at 42 C.F.R. § 405.1853(b)(2), "[e]ach position paper ***must*** *set forth* the relevant facts and arguments ***regarding the Board's jurisdiction*** *over* ***each remaining*** *matter at issue in the appeal* (as described in § 405.1840 of this subpart), ***and*** *the merits of the provider's Medicare payment claims for* ***each remaining*** *issue*." Notwithstanding the § 405.1853(b)(2) mandate that position papers address the Board's jurisdiction over ***each*** *remaining* issue, QRS, largely, does ***not*** address jurisdiction over Issue 2 (the SSI Percentage Systemic Errors issue) and, in particular, did not return to the Jurisdictional arguments set forth from the prior Jurisdictional Challenge and the ***improper*** response.

Indeed, QRS does ***not*** brief the merits of the Provider's position on the Issue 2, the SSI Percentage *Systemic Error* issue. Rather, QRS briefs ***only*** the merits of the Provider's position on Issue 1, the "SSI Percentage *Provider Specific*"[19] issue. Then later QRS withdrew Issue 1, the SSI Percentage Provider Specific issue on July 26, 2022.

Regardless, QRS' briefing of Issue 1 was sparse and, in the aggregate consisted of the following 5 sentences without any supporting exhibits:

> **Provider Specific**
>
> The Provider contends that its' SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH calculation. This is based on certain data from the State of Connecticut and the Provider that does not support the SSI percentage issued by CMS.
>
> The Provider has worked with the State of Connecticut and has learned that similar to *Loma Linda Community Hospital v. Dept. of Health and Human Services*, No. V-94-0055 (C.D. Cal. June 2, 1995), the SSI entitlement of individuals can be ascertained from State records.
>
> The Provider is seeking the Medicare Part A or Medicare Provider Analysis and Review ("MEDPAR") database, HH/HCGA/OIS, 9-07-009, which was published in the Federal Register on August 18, 2000, from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage.

[19] (Emphasis added.)

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

Essentially, QRS argues that a review of the Provider's MEDPAR data that used to compute the SSI percentage would show certain Provider specific "errors of omission" to the SSI percentage that would entitle the Provider to a correction of the SSI percentage under CMS's admission in *Baystate Medical Center* that errors occurred that did not account for all patient days in the Medicare fraction.[20]

Medicare Contractor's Final Position Paper:

On June 21, 2022, the Board received the MAC's Final Position Paper. The MAC notes that the Provider's appeal request included a disagreement with the Low Income Patient (LIP) adjustment, but as the Provider had not addressed this in their Final Position Paper, the MAC considered this issue as abandoned.[21]

The MAC also argues that the Provider's Final Position only briefs the following reasons that the SSI percentage calculated by CMS (and used by the MAC to settle its cost report) were improperly computed:

- Provider Specific – CMS failed to include all patients that were entitled to SSI benefits in the Provider's DSH Calculation[22]
- Availability of MEDPAR and SSA Records
- Not in Agreement with Provider's Records[23]

1. Availability of MEDPAR and SSA Records

The Medicare Contractor states that the statutory basis for the Provider to obtain the data relating to the SSI data is the Medicare Prescription Drug, Improvement and Modernization Act of 2003(Pub. L. 108-173) (the "MMA"). Specifically, MMA § 951 directs the Secretary to begin providing hospitals the information necessary to "compute the number of patient days used in computing the disproportionate patient percentage no later than December 8, 2004.[24]

The Medicare Contractor explains that the Secretary published her method for complying with the MMA *in the August 12, **2005** Federal Register*. CMS explained that:

> We interpret section 951 to require the Secretary to arrange to furnish to hospitals the data necessary to calculate both the Medicare and Medicaid

[20] Provider's Final Position Paper at 12 (May 26, 2022).
[21] Medicare Contractor's Final Position Paper at 7 (June 21, 2022).
[22] As noted previously above, the Provider Specific issue was subsequently withdrawn on July 26, 2022.
[23] MAC's Final Position Paper at 8.
[24] *Id*. at 19.

> fractions. With respect to both the Medicare and Medicaid fractions we interpret section 951 to require CMS to arrange to furnish the personally identifiable information that that would enable a hospital to compare and verify its records, in the case of the Medicare fraction, against the [sic] CMS' records, and in the case of the Medicaid fraction, against the State Medicaid agency's records.[25]

The Medicare Contractor goes on to explain that CMS stated that it calculated the Medicare fraction using data from the MedPAR Limited Data Set ("LDS") which was established in a notice published in the August 18, 2000 Federal Register. CMS determined that it would comply with Section 951 of the MMA by releasing MedPAR LDS data to providers:

> *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 SSSI and Medicare at the hospital's request, regardless of whether there is a properly pending appeal related 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 Federal fiscal years that encompass the hospital's cost reporting period. Under this provision, the hospital will be able to use these [this] 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.[26]

The Medicare Contractor concludes by stating that according to CMS, *the Provider requested and* ***received MedPAR data for analysis back in November 2019***. It is unclear why the Provider has been unable to verify the data.[27]

2. Not in Agreement with Provider's Records

The Medicare Contractor explains that, on April 28, 2010, CMS published Ruling 1498-R to respond to a court order in *Baystate v. Leavitt*. The Ruling instructed Medicare Contractors to resolve each properly pending DSH appeal of the SSI fraction data matching process issue by applying a suitably revised data matching process, *i.e*. the process adopted in the FY 2011 final rule. CMS' action eliminated any actual case or controversy regarding the hospital's previously calculated SSI fraction and DSH payment adjustment and thereby rendered moot each properly pending claim in a DSH appeal

[25] 70 FR 47438-47439 (Aug. 12, 2005) at 47438.
[26] *Id*. at 47439.
[27] MAC's Final Position Paper at 20.

involving the previous SSI percentage matching methodology. As a result, CMS stripped the Board and the other administrative tribunals of jurisdiction over these appeals.[28]

The Medicare Contractor contends based on 42 C.F.R. § 405.1867, the Board must comply with CMS Ruling 1498-R and as a result, the Board no longer has jurisdiction over this issue. The Medicare Contractor points to PRRB Dec. Nos. 2017-D11 and 2017-D12. Specifically, the Board ruled, CMS Ruling 1498-R rendered moot any appeal of the SSI percentage data matching issue prior to the Ruling.

Request for Postponement

On August 10, 2022, QRS requested a postponement of the August 25, 2022 hearing "pending the final outcome of Pomona Valley Hospital Med v. Xavier Becerra, 20-5250 . . . in the United States Court of Appeals for District of Columbia Circuit which is scheduled for oral argument on September 06, 2022." More specifically, QRS requested that the "DSH Payments – SSI Percentage" issue be sayded pending the outcome of the Pomona Vallie Hospital case because that "case deals with substantially similar issues to those addressed in PRRB Case Number 17-2097 namely the providers challenged the inaccuracy of the SSI Percentage." QRS then proposed a new hearing date of August 25, 2023, pending the outcome of the above-mentioned case.

Board Decision:

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2008), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the intermediary, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

With respect to position papers, the regulations at 42 C.F.R. § 405.1853(b)(2) state the following:

> Each position paper *must set forth the relevant facts* and arguments regarding the Board's jurisdiction over each remaining matter at issue in the appeal, *and the merits* of the provider's Medicare payment claims for each remaining issue.[29]

Board Rule 27 incorporates the requirements for preliminary position papers as delineated in Board Rule 25 (as updated effective November 1, 2021). In this regard, it states the following, in pertinent part:

> **Rule 27 Final Position Papers**
>
> ****
>
> **27.2 Content**

[28] *Id*. at 30.
[29] (Italics emphasis added.)

The final position paper should address each issue remaining in the appeal. The *minimum* requirements for the position paper narrative and exhibits are the same as those outlined for preliminary position papers at Rule 25.[30]

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Rule 25 Preliminary Position Papers

25.1 Content of Position Paper Narrative

The text of the position papers must include the elements addressed in the applicable subsection.

25.1.1 Provider's Position Paper

The provider's preliminary position paper must:

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

B. For ***each*** issue that has not been fully resolved, provide a ***fully*** developed narrative that:

- States the material facts that support the provider's claim.
- Identifies the controlling authority (*e.g.*, statutes, regulations, policy, or case law) supporting the provider's position.
- Provides a conclusion applying the material facts to the controlling authorities.

C. Comply with Rule 25.2 addressing Exhibits.

****

25.2 Position Paper Exhibits

25.2.1 General

With the position papers, the parties must exchange ***all*** available documentation as exhibits to fully support your position. . . .

25.2.2 Unavailable and Omitted Documents

[30] (Italics emphasis added.)

> If documents necessary to support your position are still unavailable, identify the missing documents, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
> 2. Explain why the documents remain unavailable;
> 3. State the efforts made to obtain the documents; and
> 4. Explain when the documents will be available.
>
> Once the documents become available, promptly forward them to the Board and the opposing party. Common examples of unavailable documentation include pending discovery requests, pending requests filed under the federal Freedom of Information Act (also known as FOIA requests), or similar requests for information pending with a state Medicaid agency.[31]

Indeed, these content requirements were referenced in the December 10, 2021 Notice of Hearing and Critical Due Dates, as previously quoted above. Similarly, the Board notes that the commentary to Board Rule 23.3 explains the position paper requirements as follows: "

> The regulations and Board Rules impose preliminary position paper requirements that ensure full development of the parties' positions in order to foster efficient use of the administrative review process. The due date timeframe is set to give the parties the optimal opportunity to ***fully*** develop their case. [32]Because the date for adding issues will have expired and transfers are to be made ***prior to*** filing the preliminary position papers, the Board requires preliminary position papers to be ***fully*** developed and include ***all*** available documentation necessary to provide a thorough understanding of the parties' positions.

Finally, the regulations at 42 C.F.R. § 405.1868 state the following:

> (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-

[31] (Underline emphasis added.)
[32] (Underline emphasis added.)

(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.

In reviewing the final position paper filed for the Provider in Case No 17-2097, the Board notes that the filing was ***not*** for Case No. 17-2097. As noted above, the filing was for another Danbury Case for FY 2012 under Case No. 16-0871 as confirmed by both the cover letter, the caption for the final position paper, the statement of the facts, and the amount in controversy for the Medicaid eligible days at issue in Case No. 16-0871 (and could not apply to Case No. 17-2097 since more than 2 months prior to the May 26, 2022 filing QRS had withdrawn Issue 7 pertaining to Medicaid eligible days from Case No. 17-2097 on March 10, 2022). Indeed, this was the ***exact*** same final position paper that QRS had filed roughly 2.5 months earlier in Case No. 16-0871 on March 26, 2022 as reflected in the caption and content. Accordingly, pursuant to its authority under 42 C.F.R. §§ 1853(b) ***and*** 405.1868(a)-(b), the Board dismisses Case No. 17-2097 because QRS failed to submit the Provider's final position paper for Case No. 17-2097 that briefed then remaining issues ***in this case*** which at that time were both Issue 1 (the SSI Percentage Provider Specific issue) and Issue 2 (the SSI Percentage Systemic Errors issue).

Even if it could be argued that the final position paper should still be applicable to this case, the filing would still be fatally flawed. In reviewing both the Provider's appeal request, the Provider's final position paper, and the Provider withdrawal of **Issue 1**, the Board finds:

1. QRS identifies Issue 1 in the appeal request as the "SSI Percentage (Provider Specific)" issue while it identifies Issue 2 as the "SSI Percentage (Systemic Errors)" issue.

2. The Provider's Final Position Paper filed by QRS briefs Issue 1, the SSI Percentage (Provider Specific)" issue and does not brief Issue 2, the "SSI Percentage (Systemic Errors)" issue as confirmed by the fact that the relevant section of the position paper is entitled "Provider Specific."

3. QRS withdrew Issue 1, the "SSI Percentage (Provider Specific)" issue, on July 26, 2022.

4. QRS did not brief Issue 2, the "SSI Percentage (Systemic Errors)" issue and, as noted in Board Rule 25.2, [i]f the provider fails to brief an appealed issue in its position paper, the Board will consider the unbriefed issue abandoned and effectively withdrawn."

Based on the above findings, the Board finds that QRS effectively withdrew Issue 2 because it failed to brief the issue as part of the Provider's final position paper. This again highlights why the position paper filed in this case was ***not for this case***.[33] Accordingly, after QRS withdrew Issue 1, there were no

[33] The Board notes that, in the improperly filed Response to the Jurisdictional Challenge, QRS did correctly refer to Issue 2 as the "SSI Systemic issue." This reinforces the fact that the final position paper filed did not pertain to this case and did not pertain to Issue 2, the SSI Percentage Systemic Errors issue.

remaining issues in the case and, as a result, the Board hereby closes the case. This is a separate and independent basis for dismissing Case No. 17-2097.

Notwithstanding even if the briefing of Issue 1 could be construed as being intended for Issue 2, the Board finds that QRS failed to properly brief the issue in compliance with the content requirements for position papers and with the instructions included in the December 10, 2021 Notice of Hearing and Critical Due Dates. This is a separate and independent basis for dismissing Issue 2.

Per the Provider's appeal request, the issue statement for Issue 2 centers on "systemic errors" in the revised data matching process adopted by CMS in the FY 2011 IPPS final rule as a result of the *Baystate* litigation and as reflected in CMS Ruling 1498-R. This *revised* data matching process was used in calculating the Provider's Medicare/SSI ratio for the cost report under appeal. The Provider questions the data used to calculate the SSI ratio but does not include any explanation of why the data is flawed.

The Board finds that the Provider failed to fully develop its case and include all available supporting documentation as required by the regulations and the Board Rules as necessary to provide the Board and the opposing party a thorough understanding of its position.[34] The briefing of this issue with only 5 sentences and no exhibits is clearly not sufficient. In this regard, the Provider failed to develop arguments regarding its dispute in its final position paper and only states that CMS' SSI percentage calculation contains multiple flaws, and it has been unable to verify the accuracy of the data used by CMS. The Provider failed to set forth the merits of its claim, explain why the agency's calculation is wrong, identify missing documents to support its claim, and explain when the documents will be available. The case has been pending at the Board since August 2017 and, without a good cause showing to the contrary, the Board concludes that the Provider has had adequate time to prepare its arguments and, to the extent it did not have sufficient time, then it needed to request an extension on filing its position paper.[35]

The Board finds that the Provider has essentially abandoned the SSI – Systemic Errors issue by filing a perfunctory position paper that did not include any discussion or analysis of the MedPAR data files that were supplied by CMS ***more than 2.5 years ago*** according to the Medicare Contractor in November 2019. Moreover, even if QRS disagrees with the Medicare Contractor's statement, QRS' filing of the final position paper *failed to comply with Board Rule 25.2.2* in that QRS failed to explain therein why the MEDPAR documents remained unavailable, the efforts made to obtain the MEDPAR documents over the 5 years the appeal has been pending, and explain when those MEDPAR documents would be made available.[36] Indeed, if QRS did disputed that characterization, it could have responded to the Medicare Contractor's final position paper; however, QRS failed to file a

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[34] *See, e.g.*, Commentary to Board Rule 23.2 (as quoted above).

[35] Note: This matter is currently scheduled for a hearing on August 25, 2022. On August 10, 2022, fifteen days before the scheduled hearing, the Provider requested to postpone the Hearing pending the final outcome of *Pomona Valley Hospital Med v. Xavier Becerra*, 20-5250, scheduled for oral argument in the United States Court of Appeals for the D.C. Circuit on September 6, 2022.

[36] The Board takes administrative notice that this is one of multiple cases where the Board has cited QRS for its failure to comply with Board Rule 25.2.2 and Board Rule 25 and dismissed the case for failure of QRS to properly develop the cases in its final position paper. Notwithstanding those other dismissals, QRS failed to comply with Board Rule 25 and 25.2.2 in this case.

responsive brief by the July 26, 2022 deadlines as set forth in the December 10, 2021 Notice of Hearing and Critical Due Dates.[37]

The Provider has violated Board Rule 25 and 42 C.F.R. 405.1853(b)(2) because the Provider's final position paper did not set forth the relevant facts and arguments regarding the merits of the Provider's claims. Now at this late date, the provider is stating in its postponement request, that the issue under appeal relates to the data match in the numerator, specific to codes raised in *Pomona Valley*. Indeed, even though the controlling case law is required to be discussed in the final position paper and *Pomona Valley* has been pending at the D.C. Circuit since November 2020, the final position paper does not discuss or mention *Pomona Valley*. To this end, the Board denies the postponement request as not having any foundation in the Provider's final position paper. Moreover, to the extent any data from the State of Connecticut is relevant, that also was not fully set forth in position paper, including to what extent such data was, at that time, available or not available in compliance with Board Rule 25.2.2.

Additionally, the Board agrees with the Medicare Contractor's jurisdictional challenge that, to the extent the Provider could maintain that sub-issues such as the Medicare Advantage Days issue and the Dual Eligible Days issues remain in the case,[38] such issues are separate and distinct and were not briefed in the Provider's final position paper. Indeed, had QRS done so, they would have been prohibited duplicates as the Provider is, in fact, separately appealing those issues in the optional group cases mentioned above. Similarly, the Board also finds that the LIP issue included in the Initial Appeal Request, but not addressed in the Provider's Final Position Paper was effectively abandoned.[39]

For the above multiple and independent reasons, the Board hereby dismisses Issue 2, the SSI Percentage (Systemic Errors) issue pursuant to the Board's authority under 42 C.F.R. §§ 1853(b) ***and*** 405.1868(a)-(b). As the instant case has no further issues, the Board dismisses Case No. 17-2097 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

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

For the Board:

8/22/2022

X Clayton J. Nix

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

cc: Wilson C. Leong, Esq., Federal Specialized Services

[37] *See* Notice (stating "The provider may file an optional brief in response to the arguments and evidence submitted in the Medicare Contractor's final position paper.").
[38] As discussed *supra*, QRS was not authorized to file the Jurisdictional Response \in July 2018 since QRS did not become the authorized representative until more than 3.5 years later and in this filing QRS asserted that the Part C days and dueal eligible days issues were "different aspects/components of the SSI [Systemic] issue."
[39] In accordance with Board Rule 25.1 (July 2015); Board Rule 25.3 (Nov. 2021).

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Joseph D. Glazer, Esq.
The Law Office of Joseph D. Glazer, P.C.
116 Village Blvd, Suite 200
Princeton, NJ 08540

RE: ***EJR Determination***
22-0680GC OSF Healthcare FFY 2022 Improper Calculation of the Rural Floor CIRP Group
22-0697GC Guthrie Clinic FFY 2022 Improper Calculation of the Rural Floor CIRP Group
22-0704GC UPMC Health System FFY 2022 Improper Calculation of the Rural Floor CIRP Grp.

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 16, 2022 *consolidated* request for expedited judicial review ("EJR") in the 3 above-captioned cases[1] and Federal Specialized Services' ("FSS") June 23, 2022 EJR response in all three cases as well as WPS Government Health Administrators' June 17, 2022 EJR response in Case No. 22-0680GC. On July 13, 2022, the Board issued a Scheduling Order and Notice of Stay of the 30-Day Period. In that letter, the Board also requested additional information from the Providers, to which they responded on July 15, 2022 and July 26, 2022. In its EJR response, FSS indicates that they and MACs did not note any jurisdictional challenges, but note that the applicable cost reports have not been filed, therefore they are not able to determine whether substantive claim challenges are appropriate and "reserve the right to file substantive claim challenges if appropriate."[2] Similarly, in its EJR response in Case No. 22-0680GC, WPS indicates that it is unable to conduct a substantive claim review in this case as the cost reports have not yet been filed. WPS "request[s] a reasonable amount of time to review the information once it becomes available. For those reasons, the MAC asks that the Board delay ruling on the EJR request until the MAC has been allowed a reasonable amount of time to review the filed cost reports and comment on the substantive claim aspect."

The Board has considered the MAC's extension request in Case No. 22-0680GC and **denies** this request for an *unspecified* amount of additional time to review the substantive claim information and for the Board to rule on the EJR request. In making this extension request, the MAC failed to articulate either the amount of time needed to brief their position or a persuasive reason as to *why* they needed more time to review the information once it becomes available. The MAC contends that the appeal is based on an appeal of the Federal Register and, as a result, the cost reports have not been filed and the MAC needed more time to review that information once available.

[1] The consolidated EJR request included a fourth group, Case No. 22-0682GC. The Board will address the EJR in this group under separate cover as the Providers' representative requested guidance from the Board regarding a Common Issue Related Party ("CIRP") provider. The Board issued its response on August 22, 2022, and is awaiting a response from the representative about whether it will proceed with the EJR request at this time.
[2] Response to Providers' Request for Expedited Judicial Review (June 23, 2022).

However, that reason is a *generic* argument and does *not* require participant-specific information or review. Moreover, as discussed more fully below, the Board finds that a substantive claim determination is not yet ripe as the appeal is filed based on a Federal Register appeal and no cost report has yet been filed. For these reasons, the Board denies the MAC's request for a reasonable amount of time to review the information and delay ruling on the EJR request. The decision of the Board with respect to jurisdiction and EJR is set forth below.

Board's Scheduling Order:

The Group representative, The Law Office of Joseph D. Glazer, P.C. ("Glazer") filed 8 EJR requests on June 16, 2022, and the Board had questions about whether the issues appealed in the two sets of cases are the same or different. Therefore, on June 13, 2022, the Board issued a Scheduling Order and Notice of Stay of 30-day period. The Board also notified the Glazer that the EJR requests in Case Nos. 20-0680GC, 22-0697GC, and 22-0704GC did not meet the requirements of Board Rule 42.3 as the requisite certification regarding the Schedule of Providers for these groups was not filed pursuant to Board Rule 20.

Additionally, the Board requested the following information from the group representative:

1. The Providers should submit a supplemental briefing in all cases addressing the MAC's response to their EJR request; specifically, whether Providers must file cost reports before the Board makes an EJR determination;
2. The Providers must explicitly describe the differences (factual and/or legal) in the issues between the two cases, and why they are being identified as separate issues, although both challenge the understatement of the rural floor wage index;
3. Confirm that Case Nos. 22-0678, 22-0679, 22-0680, and 22-0682 only contain one of the issues described in #2 above and confirm which issue it is.
4. Confirm that none of the providers in the 3 individual appeals have any other related providers that are pursuing, have pursued, or will pursue the issue raised in the EJR requests.

Group Representative's Response to Scheduling Order:

On July 15, 2022, Glazer filed the requisite certifications pursuant to Board Rule 20. The Group representative also responded to the Board's request for more information on July 26, 2022:

1. Providers argue "(1) if the Substantive Claim Requirement is lawful, it does not prevent EJR from being granted in the Providers' cases; and (2) the Substantive Claim Requirement is not lawful. If the Board does conclude that the Substantive Claim Requirement applies to the Providers' appeals and requires evidence of a cost report claim or protest prior to an appeal proceeding after being filed, the proper course is for the appeals to be held in abeyance until the Providers' file their respective cost reports for the affected years."[3]

[3] Providers' Response to the Board's Scheduling Order at 2.

2. The Provider distinguishes Rural Wage Index and Rural Floor as they are found in different statutory provisions and enacted at different times. "Under the Secretary's regulatory scheme, the Rural Wage Index and the Rural Floor are two different calculations with different legal requirements and different components. The Providers have followed the Secretary's own separation of the Rural Wage Index calculation and the Rural Floor calculation, and the cases are properly separated into two groups."[4]
3. The Providers confirm that Case Nos 22-0678, 22-0679, 22-0680, and 22-0682 only contain one of the issues described in Section II[5]
4. The Providers in the following 2 cases confirm that for FFY 2022 neither of them has other related providers that are pursuing, have pursued, or will pursue the issues raised in their respective EJR request:
   • 22-0678 Deaconess Hospital, Inc. (Prov. No. 15-0082, FFY 2022)
   • 22-0679 Northern Hospital of Surry County (Prov. No. 34-0003, FFY 2022)

   Corning Hospital (Prov. No. 33-0277) in Case No. 22-0695 is under common ownership or control with the two providers in Case No. 22-0697GC, Guthrie Clinic FFY 2022 Improper Calculation of the Rural Floor CIRP. Those two providers are Robert Packer Hospital (Prov. No. 39-0079) and Guthrie Cortland Medical Center (Prov. No 33-0175).[6]

Issue in the EJR Requests:

The *consolidated* EJR request describes the issue in these cases as follows:

> The Providers in each appeal assert that their Federal Fiscal Year 2022 (FFY 2022) wage indexes, and the Medicare reimbursement based on those wage indexes, were calculated in violation of the Medicare Act because of how the Secretary ("Secretary") of the United States Department of Health and Human Services treats the wage data of Section 401 hospitals.
>
> ***
>
> The Providers assert that in calculating the rural floor, the Secretary arbitrarily, capriciously, unreasonably, and unlawfully treats the wage data of Section 401 hospitals differently than the wage data of hospitals that are geographically located in the rural area of a state by: (1) excluding the wage data of Section 401 hospitals from the rural floor calculation, effectively delinking the rural floor calculation from the rural wage index calculation, and (2) excluding from the rural wage index calculation (on which the rural floor must by statute be based) the wage data of Section 401 hospitals that

[4] *Id.* at 6.
[5] *Id.* at 8.
[6] *Id.* at 8.

> reclassify by way of the Medicare Geographic Classification Review Board ("MGCRB") to a different geographic area. As a result, the Providers receive substantially lower reimbursement than required by the Social Security Act. The Providers refer to the Secretary's improper and unlawful calculation and rules at issue in the appeals as the "Section 401 Hospital Data Exclusion Policy."[7]

Statutory and Regulatory Background

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[8] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[9] for all subsection (d) hospitals located in an "urban" or "rural" area.[10]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary adjust the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.[11] The Secretary currently defines hospital labor market areas based on the delineations of statistical areas established by the Office of Management and Budget ("OMB").[12] Further, 42 U.S.C. § 1395ww(d)(3)(E) requires the Secretary to update the wage index annually and to base the update on a survey of wages and wage related costs of short-term, acute care hospitals.[13] The Secretary also takes into account the geographic reclassification of hospitals in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10) when calculating IPPS payment amounts.[14]

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[7] Providers' EJR Request at 1-2 in both sets of EJRs.
[8] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[9] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[10] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[11] 42 U.S.C. § 1395ww(d)(3)(E).
[12] *See* 84 Fed. Reg. at 42300. The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under 42 U.S.C. § 1395ww(d)(3)(E) beginning with FY 2005, the Secretary delineated hospital labor market areas based on OMB-established Core-Based Statistical Areas ("CBSAs"). The current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013. Bulletin No. 13–01.
[13] 84 Fed. Reg. at 42300.
[14] *Id.*

A. Wage Index

1. Rural Floor Adjustment

A hospital's wage index is the wage index the Secretary assigns to a specific geographical area where the hospital is located. Hospitals located in rural areas receive a wage index that applies to all rural areas in their state. Hospitals located in urban areas are grouped and treated as a single labor market based on a Core Based Statistical Area ("CBSA") in which they are physically located. Higher wage indices reflect higher labor costs in relation to the national average and, as a result, correspond to higher reimbursement rates.[15]

In 1997, Congress observed that the calculation of the wage index for all regions of a state can sometimes result in some urban hospitals being paid less than the average rural hospital in the state.[16] To correct this problem, in § 4410(a) of the Balanced Budget Act of 1997 ("BBA"), Congress provided that the wage index assigned to a hospital in an urban area must be at least as great as the wage index assigned to rural hospitals within the same state.[17] Specifically, BBA § 4410(a) states:

> For purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)) for discharges occurring on or after October 1, 1997, the area wage index applicable under such section to any hospital which is not located in a rural area (as defined in section 1886(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D)) may not be less than the area wage index applicable under such section to hospitals located in rural areas in the State in which the hospital is located.[18]

This provision is commonly referred to as the "rural floor."

2. Geographic Reclassification and "Section 401" Hospitals

In 1999, Congress recognized that, in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, Congress amended the Medicare Act to allow a hospital to seek reclassification from its geographical-based wage area to a nearby area for payment purposes if it met certain criteria and established the Medicare Geographic Review Board ("MGCRB") to administer the reclassification process.[19,20]

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[15] *Geisinger Community Med. Ctr. v. Secretary of DHHS*, 794 F. 3d 383, 386 (3d Cir. 2015).
[16] H.R. Rep. No. 105-149, at 1305 (1997).
[17] Pub. L. 105-33, § 4410(a), 111 Stat. 251, 402 (1997) (uncodified as 42 U.S.C. § 1395ww note).
[18] *Id.*
[19] *Robert Wood Johnson Univ. Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).
[20] 42 U.S.C. § 1395ww(d)(10)(D)(v).

Ten years after the MGCRB was established, Congress enacted Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA").[21] BBRA § 401 instructed the Secretary to treat certain urban hospitals that applied to the MGCRB for redesignation as rural to be treated as such. Hospitals that receive these MGCRB redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
>
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
>
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).
>
> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
>
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
>
> (IV) The hospital meets such other criteria as the Secretary may specify.[22]

In the Conference Report accompanying BBRA § 401, Congress noted that:

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and rural referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and entitled

[21] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999) (codified as 42 U.S.C. § 1395ww(d)(8)).
[22] *Id.* (emphasis added).

> to the exceptions extended to referral centers and sole community hospital's if such hospitals are so designated.[23]

The Secretary codified regulations at 42 C.F.R. § 412.103 to implement BBRA § 401.[24] This regulation is entitled "Special treatment: Hospitals located in urban areas and that apply for reclassification."

B. Request for Comments in the Federal fiscal year ("FFY") 2019 IPPS Proposed Rule

In the FFY 2019 IPPS proposed Rule published on May 7, 2018,[25] the Secretary noted that there had been numerous studies, analyses and reports identifying disparities between the wage index values for individual hospitals and wage index values among different geographic areas and ways to improve the Medicare wage index, as well as public comments made during prior rulemaking.[26] The Secretary explained that the current wage index methodology relies on labor markets that are based on statistical area definitions (core-based statistical areas ("CBSAs")) established by OMB. Hospitals are grouped in either an urban labor market (that is a metropolitan statistical area ("MSA") or metropolitan division) or a statewide rural labor market (any area of a State that is not defined as urban). The current system relies on hospital data submitted to CMS, rather than data reflecting broader labor market wages such as data from the Bureau of Labor Statistics.[27]

In prior responses to earlier requests for comments, parties had complained that the current labor market definitions and wage data sources used by the Secretary, in many instances, are not reflective of the true cost of labor for any given hospital or are inappropriate to use for this purpose or both.[28] The Secretary noted that with respect to the labor market definitions, multiple exceptions and adjustments (for example, provider reclassifications under the MGCRB and the rural floor adjustment) have been put into place in attempts to correct perceived inequities. However, the Secretary pointed out, many of these exceptions and adjustments may create or further exacerbate distortions in labor market values. The issue of "cliffs," or significant differences in wage index values between proximate hospitals, can often be attributed to one hospital benefiting from such an exception and adjustment when another hospital cannot. With respect to the wage data sources, in public comments on prior proposed rulemakings cited earlier, many stakeholders have argued that the use of hospital reported data results in increasing wage index disparities over time between high wage index areas and low wage index areas.[29]

In light of the time that had elapsed from the previous studies, reports and earlier stakeholder comments regarding the wage index values for individual hospitals, the wage index values among different geographical areas and way to improve the Medicare wage index, the Secretary specifically solicited, as part of the FFY 2019 IPPS proposed rule, public comments on the wage

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[23] H.R. Conf. Rep. No. 106-479, 512 (1999).
[24] 65 Fed. Reg. 47026, 47031, 47048 (Aug. 1, 2000).
[25] 83 Fed. Reg. 20164 (May 7, 2018).
[26] *Id.* at 20372. For a discussion of those studies and references to previous requests for comments in the Federal Register, *see* 83 Fed. Reg. at 20372-76.
[27] *Id.*
[28] *Id.*
[29] *Id.*

index, as well as suggestions and recommendations for regulatory and policy changes to the Medicare wage index.[30]

C. Secretary's Discussion in the FFY 2020 Final IPPS Rule of the Responses to the Secretary's 2019 Request for Comments on the Rural Floor

In the FFY 2020 IPPS final rule published on August 15, 2019, the Secretary finalized several changes to the hospital wage index to help mitigate the disparities between high and low wage index hospitals, including those resulting from the inclusion of hospitals with rural reclassifications under 42 C.F.R. § 412.103 in the rural floor.[31] The Secretary noted that many responses had been received as a result of the FFY 2018 IPPS proposed rule's request for comments from stakeholders regarding the wage index. Those responses reflected common concerns that the current wage index system perpetuates and exacerbates the disparities between high and low wage index hospitals. In addition, respondents also expressed concern that the calculation of the rural floor has allowed a limited number of States to manipulate the wage index system to achieve higher wages for many urban hospitals in those states at the expense of hospitals in other states, which also contributes to wage index disparities.[32]

In the final rule, the Secretary proposed several different policies to address these wage index disparities.[33] Relevant to the issue under appeal here are the Secretary's policies to prevent allegedly inappropriate payment increases due to rural reclassifications made under the provisions of 42 C.F.R. § 412.103.[34,35] The two policy changes relevant to these cases impacted the rural floor. Specifically, as part of the final rule, the Secretary finalized without modification the 2 policies:

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[30] *Id.* at 20377.

[31] The Secretary announced the proposed changes in the FFY IPPS proposed rule published on May 7, 2019. 84 Fed Reg. 19158, 19396-98 (May 3, 2019).

[32] 84 Fed. Reg. 42044, 42325 (Aug. 16, 2019).

[33] *See generally id.* at 42336-42339.

[34] 42 C.F.R. § 412.103 states in relevant part that:

> (a) General criteria. A prospective payment hospital that is located in an urban area (as defined in subpart D of this part) may be reclassified as a rural hospital if it submits an application in accordance with paragraph (b) of this section and meets any of the following conditions:
> (1) The hospital is located in a rural census tract of a Metropolitan Statistical Area (MSA) as determined under the most recent version of the Goldsmith Modification, the Rural–Urban Commuting Area codes, ...
> (2) The hospital is located in an area designated by any law or regulation of the State in which it is located as a rural area, or the hospital is designated as a rural hospital by State law or regulation.
> (3) The hospital would qualify as a rural referral center as set forth in § 412.96, or as a sole community hospital as set forth in § 412.92, if the hospital were located in a rural area.
>
> ****
>
> (7) For a hospital with a main campus and one or more remote locations under a single provider agreement where services are provided and billed under the inpatient hospital prospective payment system and that meets the provider-based criteria at § 413.65 of this chapter as a main campus and a remote location of a hospital, the hospital is required to demonstrate that the main campus and its remote location(s) each independently satisfy the location conditions specified in paragraphs (a)(1) and (2) of this section.

[35] *Id.*; 84 Fed. Reg. at 42332.

1. The policy "to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103)."[36]

2. The policy, "for purposes of applying the provisions of [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[37]

Notwithstanding his adoption of these 2 policies, the Secretary did not codify them into the Code of Federal Regulations.

1. Removal of Urban to Rural Reclassification from the Calculation of the Rural Floor

In the FFY 2020 IPPS proposed rule,[38] the Secretary had announced his proposal to remove urban reclassifications from the calculation of the rural floor under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103). In the FY 2020 IPPS final rule, the Secretary implemented that proposal stating that he believes that the proposed calculation methodology is permissible under the 42 U.S.C. § 1395ww(d)(8)(E) and BBA § 4410(a) which established the rural floor.[39] The Secretary maintains that § 1395ww(d)(8)(E) does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude wage data of reclassified hospitals calculation of the rural floor. Furthermore, the Secretary explained that BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Therefore, the Secretary believes that he has the discretion BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[40]

The Secretary contends that this policy is necessary and appropriate to address the unanticipated effects of rural floor reclassification on the rural floor and resulting wage index disparities, including the alleged manipulation of the rural floor by certain hospitals. The Secretary concludes that the inclusion of reclassified hospitals in the rural floor calculation has been an unforeseen effect of exacerbating the wage index disparities between low and high wage index hospitals.[41]

2. Removal of Urban to Rural Reclassifications from the Calculation of the Rural Floor Wage Index

Pursuant to the FFY 2020 IPPS final rule, the Secretary would continue to calculate the rural floor based on the physical non-MSA area of the state, which is the same rural area to which a hospital

[36] 84 Fed Reg. at 42336.
[37] *Id.*
[38] 84 Fed Reg. 19158, 19396-8 (May 3, 2019).
[39] 84 Fed. Reg. at 42333, 42336.
[40] *Id.* at 42333.
[41] *Id*.

is reclassified under § 1395ww(d)(8)(E). However, for purposes of calculating the rural floor wage index for a state, the Secretary would not include in the rural area the data of hospitals that have been reclassified as rural under § 1395ww(d)(8)(E). The Secretary pointed out that the legislative intent of the rural floor was to correct the anomaly of some urban hospitals being paid less than the average rural hospital in their States.[42]

The Secretary had found that, under the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural. The Secretary explained that while urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification, other states with high wage urban hospitals using 42 C.F.R. § 412.103 reclassification to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality. The Secretary believes that, excluding the data of hospitals that reclassify as rural under § 1395ww(d)(8)(E) from the rural floor wage index is necessary and appropriate to address the unanticipated effects of the rural floor reclassifications on the rural floor and the resulting wage index disparities.[43]

The Secretary contends that his reimbursement calculation is permissible under 42 U.S.C. § 1395ww(d)(8)(E) (as implemented by 42 C.F.R. § 412.103) and BBA § 4410(a)). The statute does not specify where the wage data of reclassified hospitals must be included. Therefore, the Secretary believes that he has the discretion to exclude the wage index data of such hospitals from the calculation of the rural floor. In addition, the Secretary points out, BBA § 4410(a) does not specify how the rural floor wage index is to be calculated or what data is to be included in the calculation. Consequently, the Secretary believes that he has the discretion under BBA § 4410(a) to exclude the wage data of hospitals reclassified under § 1395ww(d)(8)(E) from the calculation of the rural floor.[44]

3. Nexus between the Rural Floor and the Rural Wage Index

The Secretary includes the following explanation of how these policies impact the calculation of the rural floor:

> In the absence of broader wage index reform from Congress, **we believe it is appropriate to revise the rural floor calculation as part of an effort to reduce wage index disparities**. In response to the comment that many hospitals in states that are mostly rural benefit from the inclusion of urban hospitals in the wage index rural floor, the volume of comments that we received from stakeholders in mostly rural states supporting our proposal indicate that hospitals in such states were hurt more than helped by including hospitals with urban to rural reclassifications in the

[42] *Id.* at 42334.
[43] *Id.*
[44] *Id.*

calculation of the rural floor. While urban hospitals in mostly rural states may benefit from an increase in the rural floor due to urban to rural reclassification, as the commenters suggest, other states with high wage urban hospitals using § 412.103 reclassifications to raise the rural floor can mitigate those gains for mostly rural states, due to budget neutrality.

Regarding CMS' statutory authority, as stated in the proposed rule, we believe our proposed calculation methodology is permissible under section 1886(d)(8)(E) of the Act (as implemented in § 412.103) and the rural floor statute (section 4410 of Pub. L. 105–33). Section 1886(d)(8)(E) of the Act does not specify where the wage data of reclassified hospitals must be included. Therefore, we believe we have discretion to exclude the wage data of such hospitals from the calculation of the rural floor. Furthermore, the rural floor statute does not specify how the rural floor wage index is to be calculated or what data are to be included in the calculation. Therefore, we also believe we have discretion under the rural floor statute to exclude the wage data of hospitals reclassified under section 1886(d)(8)(E) of the Act from the calculation of the rural floor. We note that under our proposal we would continue to calculate the rural floor based on the physical non-MSA area of a state, which is the same rural area to which a hospital is reclassified under section 1886(d)(8)(E) of the Act. However, **for purposes of calculating the rural floor wage index for a state, we would not include in the rural area the data of hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act**. As we discussed in the proposed rule (84 FR 19397), the stated legislative intent of the rural floor was to correct the ''anomaly'' of ''some urban hospitals being paid less than the average rural hospital in their States.'' (Report 105–149 of the Committee on the Budget, House of Representatives, to Accompany H.R. 2015, June 24, 1997, section 10205, page 1305). Under the current rural floor wage index calculation, rather than raising the payment of some urban hospitals to the level of the average rural hospital in their State, urban hospitals may have their payments raised to the relatively high level of one or more geographically urban hospitals reclassified as rural. **We believe excluding the data of hospitals that reclassify as rural under section 1886(d)(8)(E) of the Act from the rural floor wage index is necessary and appropriate to address these unanticipated effects of rural reclassifications on the rural floor and the resulting wage index disparities, and is consistent with our authority under section 1886(d)(8)(E) of the Act and the rural floor statute**.

> We also note that our proposal is consistent with the decisions in *Geisinger Community Medical Center* v. *Secretary, United States Department of Health and Human Services,* 794 F.3d 383 (3d Cir. 2015) and *Lawrence + Memorial Hospital* v. *Burwell,* 812 F.3d 257 (2d Cir. 2016) in which the courts found that hospitals reclassified under § 412.013 must be considered rural for all purposes. Accordingly, it is CMS policy to consider hospitals reclassified as rural under § 412.103 as having rural status. For example, a hospital with a § 412.103 rural reclassification would receive the rural wage index and would use the rural mileage and wage criteria when applying for an MGCRB reclassification. **But the issue whether to include the hospital's wage data for purposes of calculating the rural floor is separate from issues of the treatment of the hospital itself.** The hospital is being treated as rural for section 1886(d) purposes regardless of whether its data is included for purposes of calculating the rural floor. We do not believe that the decisions in *Geisinger* and *Lawrence+Memorial* require any particular treatment of **the wage data of hospitals reclassified under § 412.103 for purposes of calculating the rural floor**. Those hospitals are being treated as rural because they are being allowed to reclassify through the MGCRB based on their rural designation under § 412.103, regardless of the treatment of their wage data for purposes of calculating the rural floor.
> We believe that the strict reading of ''rural for all purposes'' to which the commenters subscribe is neither required by the text of the court decisions they cite nor appropriate from a policy perspective. . . . We believe that the commenters' reading would inappropriately require that the wage data for hospitals reclassified under § 412.103 be excluded from the wage index calculation of their geographic locations. Similarly, we believe that the commenters' reading that hospitals redesignated under § 412.103 must be treated as rural for all purposes could, if taken to its logical extreme, mean we must treat those hospitals as geographically located in the rural area. That could in turn potentially reduce a State's rural wage index value. The rural area wage index is held harmless from decreases due to any effect of wage index reclassification, but the hold harmless protection does not apply to the effect on the area wage index of hospitals geographically located in the area.[45]

Accordingly, the Secretary adopted its policies:

[45] 84 Fed. Reg. at 42334-35.

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww](d)(8)(E) of the Act (as implemented at § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section [1395ww](d)(8)(C)(iii) . . ., to remove the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E) . . . (as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii) . . . .[46]

Providers' Position

The Providers request that the Board grant Expedited Judicial Review because the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks. The EJR request includes additional information about the rural floor:

> Although separate wage indexes are calculated for urban CBSAs and rural areas, the Medicare Act ties urban wage indexes to rural wage indexes (and the proper calculation of those rural wage indexes) in an important way. In 1997, Congress recognized that "[a]n anomaly that exists with the way area wage indexes are applied has resulted in some urban hospitals being paid less than the average rural hospital in their states." H.R. Rep. No. 105-149, at 1305 (1997). To correct this anomaly, Congress enacted as part of the Balanced Budget Act of 1997 a provision known as the rural floor. The statute provides in relevant part that:
>
> > the area wage index applicable… to any hospital which is not located in a rural area…may not be less than the area wage index applicable…to hospitals located in rural areas in the State in which the hospital is located.
>
> Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4410, 111 Stat. 251, 402 (1997) (reprinted at 42 U.S.C. 1395ww note). This statutory provision sets a wage index floor, pursuant to which a hospital that receives the wage index of any given urban area in a state may not be assigned a wage index lower than the rural wage index in that state. Thus, the rural floor in a state must at least equal the rural wage index in that state.[47]

[46] 84 Fed. Reg at 42336.
[47] Providers' EJR request in Case Nos. 22-0608GC et al at 4-5.

The Providers assert that their FFY 2022 wage indexes, and the Medicare reimbursement based on those wage indexes, were calculated in violation of the Medicare Act because of how the Secretary treats the wage data of Section 401 hospitals.[48] The Providers argue the "Secretary arbitrarily, capriciously, unreasonably, and unlawfully treats the wage data of Section 401 hospitals differently than the wage data of hospitals that are geographically located in the rural area of a state by: (1) excluding the wage data of Section 401 hospitals from the rural floor calculation, effectively delinking the rural floor calculation from the rural wage index calculation, and (2) excluding from the rural wage index calculation (on which the rural floor must by statute be based) the wage data of Section 401 hospitals that reclassify by way of the Medicare Geographic Classification Review Board ("MGCRB") to a different geographic area."[49]

The Providers maintain that when calculating the Medicare Wage Index, Section 401 requires the Secretary to treat Section 401 hospitals the same as hospitals that acquire rural status based on geographic location. Section 401 states that if a hospital is physically located in an urban area and meets certain criteria, "the Secretary [of HHS] shall treat the hospital as being located in the rural area … of the State in which the hospital is located for certain purposes (emphasis added)."[50] The Providers will receive a substantially lower reimbursement due to the Secretary's refusal to treat hospitals that acquire rural status through Section 401 the same as hospitals that acquire rural status by being physically located in a rural area.[51]

In response to several court actions, the Secretary issued an Interim Final Rules with comment periods that allowed Section 401 hospitals to apply and be approved for MGCRB reclassification. 81 Fed. Reg. 23428 (Apr. 21, 2016) and 86 Fed. Reg. 24735 (May 10, 2021).[52] The Providers maintain that the Secretary continues to administer differential treatment in the wage index process of hospitals acquiring rural status. "A Section 401 hospital must be treated as being located in the rural area of the state for various purposes under the Medicare Act, including calculating the rural floor and the rural wage index on which that rural floor must be based."[53] The Provider points out the Secretary treats Section 401 hospitals than geographically located hospitals during the rural floor calculation: (1) the Secretary excludes the wage data of all Section 401 hospitals from the rural floor calculation, and (2) when calculating the rural wage index (on which the rural floor must be based), the Secretary excludes the wage data of Section 401 hospitals that have an active MGCRB reclassification to another area.[54]

Decision of the Board

The participants that comprise the group appeal within this EJR request have filed an appeal involving FFY 2020 based on their appeals from the FFY 2020 IPPS final rule.

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[48] Providers' EJR Request at 1.
[49] Providers' EJR Request at 2.
[50] *Id*. at 6.
[51] Providers' EJR Request at 7.
[52] *Id.* at 7.
[53] *Id.* at 8.
[54] *Id.* at 8.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in the three groups appealed from the FFY 2022 IPPS final rule.[55] The Board has determined the participants' documentation for each of the groups shows that the estimated amount in controversy exceeds $50,000, as required for a group appeal.[56] The appeals were timely filed and the Board has not identified a statute or regulation that precludes administrative or judicial review of the group issue. 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. Application of 42 C.F.R. § 405.1873

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 42 C.F.R. § 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.

[55] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).
[56] *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 re-imbursement amount for each specific self-disallowed item.[57]

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

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

[57] (Bold and underline emphasis added.)

> 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**.[58]

These regulations are applicable to the cost reporting periods in these group cases.

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

As explained above, the relevant *cost reporting periods* for the participants in these group appeals that are impacted by the FFY 2022 IPPS final rule begin well after January 1, 2016 and, as such, are subject to 42 C.F.R. § 405.1873 and related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[59] 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))"[60] 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"[61] 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.[62]

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[58] (Bold and underline emphasis added.)
[59] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[60] (Emphasis added.)
[61] 42 C.F.R. § 405.1873 is entitled "Board review of compliance with the reimbursement requirement of an appropriate cost report claim."
[62] *See* 42 C.F.R. § 405.1873(a),

However, the Board notes that, when the participants in a group have not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the relevant participants' cost reports included an appropriate claim for the specific item under appeal would not yet be ripe.[63] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such 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, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would ***not*** stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature and the Board denies the Medicare Contractor's request to stay the EJR proceedings to both allow the Providers to file their cost reports for the fiscal years at issue in the case and allow the Medicare Contractor an opportunity to review those as-filed cost reports for compliance with § 513.24(j).

That said, *if subsequent to the Federal Register appeal being filed*, one or more participants files its cost report, then any party may raise a Substantive Claim Challenge regarding those participants and submit argument and evidence supporting their position. Here, no party has asserted that any of the participants in these Federal Register appeals later filed its cost report ***and*** failed to properly make a cost report substantive claim for the matter at issue.

Based on the above findings, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in these cases.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to treat Section 401 hospitals as not being located in a rural area for the purpose of the rural floor calculation and to assign a

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[63] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

wage index to urban hospitals that was lower than the wage index assigned to rural hospitals was made through notice and comment in the form of an uncodified regulation.[64] In the preamble to FFY 2020 IPPS final rule, the Secretary announced several different policies to address wage index disparities and the one at issue in these cases involves the rural floor. Specifically, in this final rule, the Secretary announced the following two policies to address wage disparities and these policies impacted the calculation of the rural floor set for FFY 2022:

1. The policy "to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103)";[65] and

2. The policy, "for purposes of applying the provisions of [42 U.S.C. § 1395ww(d)(8)(C)(iii)], to remove the wage data of urban hospitals reclassified as rural under [42 U.S.C. § 1395ww(d)(8)(E)] (as implemented at § 412.103) from the calculation of 'the wage index for rural areas in the State in which the county is located' referred to in [42 U.S.C. § 1395ww](d)(8)(C)(iii)]."[66]

The Secretary did *not* incorporate the above new policies setting forth a modification to the wage index calculation for the rural floor and to remove the wage data of urban hospitals reclassified as rural from the calculation of the wage index into the Code of Federal Regulations. However, it is clear from the use of the following language in the preamble to the FFY 2020 IPPS final rule that the Secretary intended to bind the regulated parties and establish a binding *uniform* payment policy through formal notice and comment:

> After consideration of the public comments we received, for the reasons discussed in this final rule and in the proposed rule, we are finalizing without modification our proposal to calculate the rural floor without including the wage data of urban hospitals reclassified as rural under section [1395ww](d)(8)(E) . . . (as implemented at [42 C.F.R.] § 412.103). Additionally, we are finalizing without modification our proposal, for purposes of applying the provisions of section § [1395ww](d)(8)(C)(iii) . . . to remove the wage data of urban hospitals reclassified as rural under section 1395ww](d)(8)(E) . . . (as implemented at § 412.103) from the calculation of ''the wage index for rural areas in the State in which the county is located'' referred to in section [1395ww](d)(8)(C)(iii) . . . .[67]

Accordingly, the Board finds that the Secretary intended these rural floor policy changes to be a binding but uncodified regulation and will refer to the above policies as the "Uncodified Rural Floor Regulation." Indeed, this finding is consistent with the Secretary's obligations under 42

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[64] *See* 84 Fed. Reg. 42044, 42325-36 (section entitled "II. Changes to the Hospital Wage Index for Acute Care Hospitals, N. Policies to Address Wage Index Disparities Between High and Low Wage Index Hospitals").
[65] 84 Fed Reg. at 42336.
[66] *Id.*
[67] *Id.*

U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[68]

The Uncodified Rural Floor Regulation was set forth in the FFY 2020 IPPS Final Rule, yet the Providers in these groups have appealed from the FFY 2022 Final Rule, which indicates that this policy is still in effect –

> In the FY 2020 IPPS/LTCH PPS final rule (84 FR 42332 through 42336), we removed urban to rural reclassifications from the calculation of the rural floor to prevent inappropriate payment increases under the rural floor due to rural reclassifications, such that, beginning in FY 2020, the rural floor is calculated without including the wage data of hospitals that have reclassified as rural under section 1886(d)(8)(E) of the Act (as implemented in the regulations at § 412.103). The rural floor for this FY 2022 proposed rule continues to be calculated without the wage data of hospitals that have reclassified as rural under § 412.103. **We did not propose any changes to the rural floor policy for FY 2022.**[69]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to by the Uncodified Rural Floor Regulation published in the FFY 2020 IPPS final rule and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Rural Floor Regulation which they allege improperly removes the payment provisions established by Congress for rural floor calculation in two ways. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding the FFY 2020 IPPS final rule, there are no findings of fact for resolution by the Board;

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

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[68] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."

[69] 86 Fed. Reg. 44774, 45175 (Aug. 13, 2021) (emphasis added).

4) It is without the authority to decide the legal question of whether the Uncodified Rural Floor Regulation as published in the FFY 2020 IPPS final rule is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Rural Floor Regulation as published in the FFY 2020 IPPS final rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in these cases, the Board hereby closes the cases.

Board Members Participating:

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

For the Board:

8/25/2022

X Clayton J. Nix

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

Enclosure: Schedules of Providers

cc: Byron Lamprecht, WPS Government Health Administrators
Danelle Decker, National Government Services, Inc.
Bruce Snyder, Novitas Solutions, Inc.
Wilson Leong, Federal Specialized Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Joseph D. Glazer, Esq.
The Law Office of Joseph D. Glazer, P.C.
116 Village Blvd, Suite 200
Princeton, NJ 08540

RE: ***EJR Determination***
22-0695 Corning Hospital (Prov. No. 33-0277, FFY 2022)
22-0678 Deaconess Hospital, Inc. (Prov. No. 15-0082, FFY 2022)
22-0679 Northern Hospital of Surry County (Prov. No. 34-0003, FFY 2022)
22-0700GC UPMC Health System FFY 2022 Improper Calculation of Rural Wage Index CIRP

Dear Mr. Glazer:

The Provider Reimbursement Review Board ("Board") has reviewed the Providers' June 16, 2022 requests for expedited judicial review ("EJR") and WPS Government Health Administrator's June 17, 2022 EJR response in Case No. 22-0678. On July 13, 2022, the Board issued a Scheduling Order and Notice of Stay of the 30-Day Period. In that letter, the Board also requested additional information from the Providers, to which they responded on July 16, 2022 and July 26, 2022. In its EJR response filed only in Case No. 22-0678, WPS indicates that it is unable to conduct a substantive claim review in this case as the cost report has not yet been filed. WPS "request[s] a reasonable amount of time to review the information once it becomes available. For those reasons, the MAC asks that the Board delay ruling on the EJR request until the MAC has been allowed a reasonable amount of time to review the filed cost report and comment on the substantive claim aspect."[1]

The Board has considered the MAC's extension request in Case No. 22-0678 and **denies** this request for an *unspecified* amount of additional time to review the substantive claim information and for the Board to rule on the EJR request. In making this extension request, the MAC failed to articulate either the amount of time needed to brief their position or a persuasive reason as to *why* they needed more time to review the information once it becomes available. The MAC contends that the appeal is based on an appeal of the Federal Register and, as a result, the cost reports have not been filed and the MAC needed more time to review that information once available. However, that reason is a *generic* argument and does *not* require participant-specific information or review. Moreover, as discussed more fully below, the Board finds that a substantive claim determination is not yet ripe as the appeal is filed based on a Federal Register appeal and no cost report has yet been filed. For these reasons, the Board denies the MAC's request for a reasonable amount of time to review the information and delay ruling on the EJR request. The decision of the Board with respect to jurisdiction and EJR is set forth below.

[1] Response to Providers' Request for Expedited Judicial Review (June 17, 2022).

Board's Scheduling Order:

The Group representative, The Law Office of Joseph D. Glazer, P.C. ("Glazer") filed 8 EJR requests on June 16, 2022, and the Board had questions about whether the issues appealed in the two sets of cases are the same or different. Therefore, on June 13, 2022, the Board issued a Scheduling Order and Notice of Stay of 30-day period. The Board also notified the Glazer that the EJR requests in Case No. 20-0700GC did not meet the requirements of Board Rule 42.3 as the requisite certification regarding the Schedule of Providers for these groups was not filed pursuant to Board Rule 20.

Additionally, the Board requested the following information from the group representative:

1. The Providers should submit a supplemental briefing in all cases addressing the MAC's response to their EJR request; specifically, whether Providers must file cost reports before the Board makes an EJR determination;
2. The Providers must explicitly describe the differences (factual and/or legal) in the issues between the two cases, and why they are being identified as separate issues, although both challenge the understatement of the rural floor wage index;
3. Confirm that Case Nos. 22-0678, 22-0679, 22-0680, and 22-0682 only contain one of the issues described in #2 above and confirm which issue it is.
4. Confirm that none of the providers in the 3 individual appeals have any other related providers that are pursuing, have pursued, or will pursue the issue raised in the EJR requests.

Group Representative's Response to Scheduling Order:

On July 16, 2022, Glazer filed the requisite certification pursuant to Board Rule 20 in Case No. 22-0700GC. The Group representative also responded to the Board's request for more information on July 26, 2022:

1. Providers argue "(1) if the Substantive Claim Requirement is lawful, it does not prevent EJR from being granted in the Providers' cases; and (2) the Substantive Claim Requirement is not lawful. If the Board does conclude that the Substantive Claim Requirement applies to the Providers' appeals and requires evidence of a cost report claim or protest prior to an appeal proceeding after being filed, the proper course is for the appeals to be held in abeyance until the Providers' file their respective cost reports for the affected years."[2]
2. The Provider distinguishes Rural Wage Index and Rural Floor as they are found in different statutory provisions and enacted at different times. "Under the Secretary's regulatory scheme, the Rural Wage Index and the Rural Floor are two different calculations with different legal requirements and different components. The Providers

[2] Providers' Response to the Board's Scheduling Order at 2.

have followed the Secretary's own separation of the Rural Wage Index calculation and the Rural Floor calculation, and the cases are properly separated into two groups."[3]

3. The Providers confirm that Case Nos 22-0678, 22-0679, 22-0680, and 22-0682 only contain one of the issues described in Section II[4]

4. The Providers in the following 2 cases confirm that for FFY 2022 neither of them has other related providers that are pursuing, have pursued, or will pursue the issues raised in their respective EJR request:
   • 22-0678 Deaconess Hospital, Inc. (Prov. No. 15-0082, FFY 2022)
   • 22-0679 Northern Hospital of Surry County (Prov. No. 34-0003, FFY 2022)
   Corning Hospital (Prov. No. 33-0277) in Case No. 22-0695 is under common ownership or control with the two providers in Case No. 22-0697GC, Guthrie Clinic FFY 2022 Improper Calculation of the Rural Floor CIRP. Those two providers are Robert Packer Hospital (Prov. No. 39-0079) and Guthrie Cortland Medical Center (Prov. No 33-0175).[5]

Issue in the EJR Requests:

The EJR request filed in each case is the same and each describes the issue in these cases as follows:

> The Provider in this appeal asserts that their Federal Fiscal Year 2022 (FFY 2022) wage index, and the Medicare reimbursement based on that wage index, were calculated in violation of the Medicare Act. Specifically, the Provider asserts that the Secretary ("Secretary") of the United States Department of Health and Human Services arbitrarily, capriciously, unreasonably, and unlawfully excluded from the rural wage index calculation, the wage date [*sic* data] of Section 401 hospitals that reclassify by way of the Medicare Geographic Classification Review Board ("MGCRB") to a different geographic area. This resulted in substantially lower reimbursement to the Provider. The Provider uses the term "Section 401 hospital" to refer to a hospital that is physically located in an urban area and that by statute must be treated as being located in the rural area of the state in which the hospital is located for certain Medicare reimbursement purposes. Section 401 was enacted as part of the *Medicare, Medicaid and SCHIP Balanced Budget Refinement Act of 1999*. The Provider refers to the Secretary's improper and unlawful rule at issue in this appeal as the "Section 401 Hospital Data Exclusion Policy.[6]

In addition, the EJR request further explains:

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[3] *Id.* at 6.
[4] *Id.* at 8.
[5] *Id.* at 8.
[6] EJR Request at 1-2.

> The Provider challenges the Secretary's methodology for calculating the rural wage index by excluding the wage data of Section 401 hospitals that reclassify through the MGCRB to another wage area. This Section 401 Hospital Data Exclusion Policy was first announced in the Interim Final Rule with comment period published in the April 21, 2016, Federal Register, and re-stated in August 2016 in the Final Rule for FFY 2017 following the required comment period. 81 Fed. Reg. at 23434 and 81 Fed. Reg. at 56924 and 56926. In the FFY 2022 rulemaking process, the Secretary again stated that when calculating the rural wage index for a state, the agency would not treat the wage data of hospitals that acquire rural status by way of Section 401 the same as hospitals that acquire rural status by being physically located in a rural area. 86 Fed. Reg. at 45181-182.[7]

Statutory and Regulatory Background

The statute, 42 U.S.C. § 1395ww(d), sets forth a system of payment for the operating costs of acute care hospital inpatient stays under Medicare Part A based on prospectively set rates[8] known as the Inpatient Prospective Payment System ("IPPS"). Under IPPS, Medicare payments for hospital inpatient operating costs are made at predetermined, specific rates for each hospital discharge. Discharges are classified according to a list of diagnosis-related groups ("DRGs"). The base payment rate is comprised of a standardized amount[9] for all subsection (d) hospitals located in an "urban" or "rural" area.[10]

As part of the methodology for determining prospective payments to hospitals, 42 U.S.C. § 1395ww(d)(3)(E) requires that the Secretary adjust the standardized amounts for area differences in hospital wage levels by a factor reflecting the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.[11] The Secretary currently defines hospital labor market areas based on the delineations of statistical areas established by the Office of Management and Budget ("OMB").[12] Further, 42 U.S.C. § 1395ww(d)(3)(E) requires

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[7] EJR Request at 10-11.
[8] 84 Fed. Reg. 42044, 42052 (Aug. 16, 2019).
[9] The standardized amount is based on per discharge averages from a base period and are updated in accordance with 42 U.S.C. §1395ww(d). Sections 1395ww(d)(2)(C) and (d)(2)(B)(ii) require that updated base-year per discharge costs be standardized in order to remove the cost data that effects certain sources of variation in costs among hospitals. These include case mix, differences in area wage levels, cost of living adjustments for Alaska and Hawaii, indirect medical education costs, and payments to disproportionate share hospitals. 59 Fed. Reg. 27433, 27765-27766 (May 27, 1994). Section 1395ww (d)(3)(E) of the Act requires the Secretary from time-to-time to estimate the proportion of the hospitals' costs that are attributable to wages and wage-related costs. The standardized amount is divided into labor-related and nonlabor-related amounts; only the portion considered the labor related amount is adjusted by the wage index. 71 Fed. Reg. 47870, 48146 (August 18, 2006).
[10] 42 U.S.C. § 1395ww(d)(2)(A)-(D).
[11] 42 U.S.C. § 1395ww(d)(3)(E).
[12] *See* 84 Fed. Reg. at 42300. The wage index is calculated and assigned to hospitals on the basis of the labor market area in which the hospital is located. Under 42 U.S.C. § 1395ww(d)(3)(E) beginning with FY 2005, the Secretary delineated hospital labor market areas based on OMB-established Core-Based Statistical Areas ("CBSAs"). The

the Secretary to update the wage index annually and to base the update on a survey of wages and wage related costs of short-term, acute care hospitals.[13] The Secretary also takes into account the geographic reclassification of hospitals in accordance with 42 U.S.C. §§ 1395ww(d)(8)(B) and 1395ww(d)(10) when calculating IPPS payment amounts.[14]

A. Geographic Reclassification and "Section 401" Hospitals

In 1999, Congress recognized that, in some cases, a hospital in one geographical area may compete for the same labor pool as hospitals in a nearby, larger urban area but receive lower reimbursement because they are located in a lower wage index area. This resulted in some hospitals being underpaid for their labor costs. As a result, Congress amended the Medicare Act to allow a hospital to seek reclassification from its geographical-based wage area to a nearby area for payment purposes if it met certain criteria and established the Medicare Geographic Review Board ("MGCRB") to administer the reclassification process.[15,16]

Ten years after the MGCRB was established, Congress enacted Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 ("BBRA").[17] BBRA § 401 instructed the Secretary to treat certain urban hospitals that applied to the MGCRB for redesignation as rural to be treated as such. Hospitals that receive these MGCRB redesignations are sometimes known as "Section 401" hospitals. Codified at 42 U.S.C. § 1395ww(d)(8)(E), the statute states that:

> (i) For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall treat the hospital as being located in the rural area*** (as defined in paragraph (2)(D)) of the State in which the hospital is located.
>
> (ii) For purposes of clause (i), a subsection (d) hospital described in this clause is a subsection (d) hospital that is located in an urban area (as defined in paragraph (2)(D)) and satisfies any of the following criteria:
>
> (I) The hospital is located in a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)).

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current statistical areas (which were implemented beginning with FY 2015) are based on revised OMB delineations issued on February 28, 2013. Bulletin No. 13–01.

[13] 84 Fed. Reg. at 42300.

[14] *Id.*

[15] *Robert Wood Johnson Univ. Hosp. v. Thompson*, 297 F. 3d. 273, 276 (3d Cir. 2002).

[16] 42 U.S.C. § 1395ww(d)(10)(D)(v).

[17] *See* Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, Public L. 106-113, app. F. § 401, 113, Stat. 1501, 1501A-321 (Nov. 29, 1999) (codified as 42 U.S.C. § 1395ww(d)(8)).

> (II) The hospital is located in an area designated by any law or regulation of such State as a rural area (or is designated by such State as a rural hospital).
>
> (III) The hospital would qualify as a rural, regional, or national referral center under paragraph (5)(C) or as a sole community hospital under paragraph (5)(D) if the hospital were located in a rural area.
>
> (IV) The hospital meets such other criteria as the Secretary may specify.[18]

In the Conference Report accompanying BBRA § 401, Congress noted that:

> Hospitals qualifying under this section shall be eligible to qualify for all categories and designations available to rural hospitals, including sole community, Medicare dependent, critical access, and rural referral centers. Additionally, qualifying hospitals shall be eligible to apply to the [MGCRB] for geographic reclassification to another area. The [MGCRB] shall regard such hospital as rural and entitled to the exceptions extended to referral centers and sole community hospital's if such hospitals are so designated.[19]

The Secretary codified regulations at 42 C.F.R. § 412.103 to implement BBRA § 401.[20] This regulation is entitled "Special treatment: Hospitals located in urban areas and that apply for reclassification."

B. Interim Final Rule Published on April 21, 2016 and Finalized in the FY 2017 IPPS Final Rule Published on August 22, 2016

Until April 21, 2016, the Secretary did not allow Section 401 hospitals to apply to the MGCRB for wage index reclassification, which providers challenged in federal court. Two different U.S. Circuit Courts of Appeal found this policy to be unlawful. In one case, the Third Circuit Court of Appeals held:

> As discussed, a hospital's urban-rural geographic location has a dispositive effect on the hospital's designated standardized rate and wage index. In turn, it has a dispositive effect on the Board reclassification process, the statutory purpose of which is to redesignate the hospital from rural to urban or vice versa for purposes of receiving a new standardized rate or wage index. *See* 42 U.S.C. § 1395ww(d)(10)(C). This bolsters our conclusion that Congress intended Section 401 to apply to these specific processes. Thus, we must read Section 401 as mandating that for purposes of

[18] *Id.* (emphasis added).
[19] H.R. Conf. Rep. No. 106-479, 512 (1999).
[20] 65 Fed. Reg. 47026, 47031, 47048 (Aug. 1, 2000).

> Board reclassification, which is inextricably intertwined with a hospital's rural or urban designation, the Board shall treat the hospital as rural.[21]

Similarly, the Second Circuit Court of Appeals found the Secretary's policy in 42 C.F.R. § 412.230(a)(5)(iii) of excluding Section 401 hospitals from the calculation of the rural wage index of a state invalid because it is at odds with the statute at 42 U.S.C. § 1395ww(d)(8)(E), which states:

> For purposes of this subsection, not later than 60 days after the receipt of an application (in a form and manner determined by the Secretary) from a subsection (d) hospital described in clause (ii), the Secretary ***shall*** treat the hospital as being located in the rural area (as defined in paragraph (2)(D)[5]) of the State in which the hospital is located.[22]

In response to these two Circuit Court cases that held the Secretary's poliy was unlawful, the Secretary issued an Interim Final Rule with comment period that allowed Section 401 hospitals to apply and be approved for MGCRB reclassification for purposes of the wage index calculation:

> On July 23, 2015 the Court of Appeals for the Third Circuit issued a decision in Geisinger Community Medical Center v. Secretary, United States Department of Health and Human Services, 794 F.3d 383 (3d Cir. 2015). Geisinger Community Medical Center ("Geisinger"), a hospital located in a geographically urban Core-Based Statistical Area (CBSA), obtained rural status under § 412.103, but was unable to receive additional reclassification through the MGCRB while still maintaining its rural status under § 412.230(a)(5)(iii). To receive reclassification through the MGCRB under existing regulations, Geisinger would have had to first cancel its § 412.103 urban-to-rural reclassification and use the proximity requirements for an urban hospital rather than take advantage of the broader proximity requirements for reclassification granted to rural hospitals. (We refer readers to § 412.230(b)(1), which states that a hospital demonstrates a close proximity with the area to which it seeks redesignation if the distance from the hospital to the area is no more than 15 miles for an urban hospital and no more than 35 miles for a rural hospital.) Geisinger challenged as unlawful the regulation at § 412.230(a)(5)(iii) requiring cancelation of its rural reclassification prior to applying for reclassification through the MGCRB. In Geisinger Community Medical Center v. Burwell, 73 F. Supp.3d 507 (M.D. Pa. 2014), the United States District Court for the Middle District of Pennsylvania upheld the regulation at § 412.230(a)(5)(iii) and granted summary judgment in favor of CMS.

[21] *Geisinger Cmty. Med. Ctr. v. Sec'y U.S. Dep't of Health & Hum. Servs.,* 794 F.3d 383, 393 (3d Cir. 2015).
[22] *Lawrence + Mem'l Hosp. v. Burwell*, 812 F.3d 257, 265 (2d Cir. 2016) (emphasis added).

The Court of Appeals for the Third Circuit reversed the decision of the District Court, holding that the language of section 1886(d)(8)(E)(i) of the Act is unambiguous in its plain intent that "the Secretary shall treat the hospital as being located in the rural area," inclusive of MGCRB reclassification purposes, thus invalidating the regulation at § 412.230(a)(5)(iii). On February 4, 2016, the Court of Appeals for the Second Circuit issued its decision in Lawrence + Memorial Hospital v. Burwell, No. 15-164, 2016 WL 423702 (2d Cir. February 4, 2016), essentially following the reasoning of the Third Circuit Geisinger decision.

While these decisions currently apply only to hospitals located within the jurisdictions of the Second and Third Circuits, we believe that maintaining the regulations at § 412.230(a)(5)(iii) in other places nationally would constitute inconsistent application of reclassification policy based on jurisdictional regions. In the interest of creating a uniform national reclassification policy, we are removing the regulation text at § 412.230(a)(5)(iii). We are also revising the regulation text at § 412.230(a)(5)(ii) to allow more than one reclassification for those hospitals redesignated as rural under § 412.103 and—simultaneously seeking reclassification through the MGCRB. Specifically, we are revising § 412.230(a)(5)(ii) to state that a hospital may not be redesignated to more than one area, except for an urban hospital that has been granted redesignation as rural under § 412.103 and receives an additional reclassification by the MGCRB. Therefore, effective for reclassification applications due to the MGCRB on September 1, 2016, for reclassification first effective for FY 2018, a hospital could apply for a reclassification under the MGCRB while still being reclassified from urban to rural under § 412.103. Such hospitals would be eligible to use distance and average hourly wage criteria designated for rural hospitals at § 412.230(b)(1) and (d)(1). In addition, effective with the display date of this IFC, a hospital that has an active MGCRB reclassification and is then approved for reclassification under § 412.103 would not lose its MGCRB reclassification; that is, a hospital with an active MGCRB reclassification can simultaneously maintain rural status under § 412.103, and receive a reclassified urban wage index during the years of its active MGCRB reclassification and would still be considered rural under section 1886(d) of the Act and for other purposes. We would also apply the policy in this IFC when deciding timely appeals before the Administrator under § 412.278 for FY 2017 that were denied by the MGCRB due to existing § 412.230(a)(5)(ii) and (iii), which do not permit simultaneous § 412.103 and MGCRB reclassifications.

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> That is, for wage index calculation and payment purposes, when there is both a § 412.103 reclassification and an MGCRB reclassification, the MGCRB reclassification would control for wage index calculation and payment purposes. Therefore, although we are amending our policy with this IFC so that a hospital can simultaneously have a reclassification under the MGCRB and an urban to rural reclassification under § 412.103, ***we are separately clarifying that we will exclude hospitals with § 412.103 reclassifications from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area***. In these circumstances, we believe it is appropriate to rely on the urban MGCRB reclassification to include the hospital's wage data in the calculation of the urban CBSA wage index. Further, we believe it is appropriate to rely on the urban MGCRB reclassification to ensure that the hospital be paid based on its urban MGCRB wage index. While rural reclassification confers other rural benefits besides the wage index under section 1886(d) of the Act, a hospital that chooses to pursue reclassification under the MGCRB (while also maintaining a rural reclassification under § 412.103) would do so solely for wage index payment purposes.[23]

Following the comment period, the Secretary finalized the policy in the IPPS Final Rule for FFY 2017, and stated that in the Interim Final Rule with comment the following policy:

> [W]e separately clarified that we will exclude hospitals with § 412.103 redesignations from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area.[24]

The Secretary then finalized this policy as part of the 2017 IPPS Final Rule that was published on August 22, 2016.[25] It is this policy that the Providers in these cases are challenging.

Providers' Position

The Providers request that the Board grant Expedited Judicial Review because the Board has jurisdiction over the appeal but lacks the authority to grant the relief the Provider seeks.

The Providers assert that their FFY 2022 wage indexes, and the Medicare reimbursement based on those wage indexes, were calculated in violation of the Medicare Act because of how the Secretary treats the wage data of Section 401 hospitals in calculating that index.[26] The Providers argue the Secretary "arbitrarily, capriciously, unreasonably, and unlawfully excluded from the rural wage

[23] 81 Fed. Reg. 23428 at 23433-34 (April 21, 2016) (emphasis added).
[24] 81 Fed. Reg. 56762 at 56924 (Aug. 22, 2016).
[25] 81 Fed. Reg. 23434; 81 Fed. Reg. at 56924, 56926.
[26] Providers' EJR Request at 1.

index calculation, the wage date of Section 401 hospitals that reclassify by way of the Medicare Geographic Classification Review Board ("MGCRB") to a different geographic area" and that "[t]his resulted in substantially lower reimbursement to the Provider."[27]

The Providers are challenging the Secretary's methodology for calculating the rural wage index by *excluding* the wage data of Section 401 hospitals that reclassify through the MGCRB to another wage area, in accordance with the policy, discussed above, that was introduced in the April 21, 2016 Interim Final Rule and finalized in the 2017 IPPS Final Rule that was published on August 22, 2016.[28] The Providers explain that in the 2020 rulemaking process, the Secretary again state that, when calculating the rural wage index for a state, the agency would not treat the wage data of section 401 rural hospitals the same as hospitals that acquire rural status by being physically located in a rural area.[29] The Providers conclude that the Board does not have the authority to dictate the Secretary's rules and policies for determining the rural wage index of a state, therefore the Board should grant EJR.

Decision of the Board

The participants that comprise the group appeal within this EJR request have filed an appeal involving FFY 2020 based on their appeals from the FFY 2020 IPPS final rule.

A. Jurisdiction and Request for EJR

As previously noted, all of the participants in the three groups appealed from the FFY 2022 IPPS final rule.[30] The Board has determined the participants' documentation for each of the groups shows that the estimated amount in controversy exceeds $10,000 as required for individual appeals and $50,000, as required for a group appeal.[31] The appeals were timely filed. Based on the above, the Board finds that it has jurisdiction for the above-captioned appeals and the underlying Providers. The estimated amount in controversy is subject to recalculation by the Medicare Contractor for the actual final amount in each case.

B. Application of 42 C.F.R. § 405.1873

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 42 C.F.R. § 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

[27] Providers' EJR Request at 1.
[28] 81 Fed. Reg. 23434; 81 Fed. Reg. at 56924 and 56926.
[29] EJR Request in Case No. 22-0695 at 10-11 (June 16, 2022).
[30] The CMS Administrator has determined that a Federal Register notice is a final determination from which a provider may appeal to the Board. *See District of Columbia Hosp. Ass'n Wage Index Grp. Appeal*, HCFA Adm'r Dec. (Jan. 15, 1993*)*, *rev'g*, PRRB Juris. Dec. (Case No. 92-1200G, Nov. 18, 1992). *See also* 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015).
[31] *See* 42 C.F.R. § 405.1837.

> 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 re-imbursement amount for each specific self-disallowed item.[32]

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.

[32] (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**.[33]

These regulations are applicable to the cost reporting periods in these individual and group cases.

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

As explained above, the relevant *cost reporting periods* for the Providers in the individual appeal and the participants in the group appeal (as set forth in the caption) are impacted by the FFY 2022

[33] (Bold and underline emphasis added.)

IPPS final rule begin well after January 1, 2016 and, as such, are subject to 42 C.F.R. § 405.1873 and related revisions to 42 C.F.R. § 413.24(j) regarding submission of cost reports.[34] 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))"[35] 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"[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] Here, a party has raised a question ***only*** in one case, namely Case No. 22-0678. As such, it is clear that in the other cases, that Board review under § 405.1873(b) has not been triggered and the Board need not include any findings of fact or conclusions of law as to whether an appropriate claim was included. With regard to Case No. 22-0679, as set forth below, the Board finds the MAC's questions to be premature.

The Board notes that, if a provider has not filed their cost report, then § 405.1873(b) would not be triggered because the issue of whether the provider's cost report included an appropriate claim for the specific item under appeal would not yet be ripe.[38] Section 405.1873(b) sets forth the procedures for Board review of Substantive Claim Challenges:

> The Board must give the parties an adequate opportunity to submit factual evidence and legal argument regarding the question of whether the provider's cost report included an appropriate claim for the specific item under appeal. Upon receipt of timely submitted factual evidence or legal argument (if any), the Board must review such 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, for the specific item under appeal, the cost report claim requirements prescribed in § 413.24(j) of this chapter.

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[34] *See* 80 Fed. Reg. 70298, 70555-70604 (Nov. 13, 2015).
[35] (Emphasis added.)
[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] The preamble to the final rule that adopted the substantive claim regulations at 42 C.F.R. §§ 413.24(j) and 405.1973 responded to a comment about appeals from the Federal Register and confirmed that the substantive claim regulations applied to them. 80 Fed. Reg. 70298, 70569-70 (Nov. 13, 2015). However, this preamble discussion does not address the manner in which they apply. Rather, the response concludes with the following directive in § 405.1873(a)-(b): "if a party to an appeal questions whether there was an appropriate cost report claim for a specific PPS item, the Board must take evidence and argument on that question; issue findings of fact and conclusions of law on such matter; and include those findings and conclusions in both the administrative record and certain types of overall Board decisions." *Id.* at 70570.

Significantly, the regulation simply directs the Board to give an adequate opportunity to take in evidence and argument and does not discuss staying appeals based on Federal Register to allow future review and consideration of Substantive Claim Challenges. In this regard, the fact that a cost report has not been filed, it would ***not*** stop or delay the Board proceedings as set forth in § 405.1873(b). Accordingly, it is the Board's position that in these instances, any Substantive Claim Challenge would be premature and the Board denies the Medicare Contractor's request to stay the EJR proceedings to both allow the Provider to file their cost report for the fiscal year at issue in the case and allow the Medicare Contractor an opportunity to review that as-filed cost report for compliance with § 513.24(j).

That said, *if subsequent to the Federal Register appeal being filed*, the Provider files its cost report, then any party may raise a Substantive Claim Challenge regarding that Provider and submit argument and evidence supporting their position. Here, no party has asserted that the Provider later filed its cost report ***and*** failed to properly make a cost report substantive claim for the matter at issue. As a result, since the Provider has not yet filed its cost report, the Board finds that the MAC's challenge is premature and that Board review under § 405.1873(b) has not been triggered.

Based on the above findings, the Board is not obligated under 42 C.F.R. § 405.1873 to include findings on substantive claim challenges in Case No. 22-0678.

C. Analysis Regarding Appealed Issue

As set forth below, the Board finds that the Secretary's determination to exclude Section 401 hospitals from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area was made through notice and comment in the form of an uncodified regulation.[39] In the Interim Final Rule with Comment for FFY 2017 IPPS final rule, the Secretary announced this policy to exclude Section 401 hospitals from the rural wage index if they also have an active MGCRB reclassification to another area. Specifically, in the final rule the Secretary finalized and adopted the policy: "[W]e separately clarified that we will exclude hospitals with § 412.103 redesignations from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area."[40]

The Secretary did ***not*** incorporate the above new policy into the Code of Federal Regulations. However, it is clear from the language in the FFY 2017 IPPS final rule that the Secretary intended to bind the regulated parties and establish a binding *uniform* payment policy through formal notice and comment.

Accordingly, the Board finds that the Secretary intended this policy change to be a binding but uncodified regulation and will refer to the above policy as the "Uncodified Section 401 Hospital Data Exclusion Policy." Indeed, this finding is consistent with the Secretary's obligations under

[39] *See* 81 Fed. Reg. 23428, 23428 through 23438.
[40] 81 Fed. Reg. 56762 at 56924 (Aug. 22, 2016).

42 U.S.C. § 1395hh(a)(2) to promulgate any "substantive legal standard governing . . . the payment of services" as a regulation."[41]

The policy to exclude Section 401 hospitals classified as rural from the rural wage index was set forth in the Interim Final Rule with Comment and adopted in the FFY 2017 IPPS Final Rule, yet the Providers in these appeals have appealed from the FFY 2022 Final Rule, which indicates that this policy is still in effect –

> We exclude hospitals with § 412.103 redesignations from the calculation of the reclassified rural wage index if they also have an active MGCRB reclassification to another area. That is, if an application for urban reclassification through the MGCRB is approved, and is not withdrawn or terminated by the hospital within the established timelines, we consider the hospital's geographic CBSA and the urban CBSA to which the hospital is reclassified under the MGCRB for the wage index calculation. We refer readers to the April 21, 2016 IFC (81 FR 23428 through 23438) and the FY 2017 IPPS/LTCH PPS final rule (81 FR 56922 through 56930) for a full discussion of the effect of simultaneous reclassifications under both the § 412.103 and the MGCRB processes on wage index calculations. For a discussion on the effects of reclassifications under § 412.103 on the rural area wage index and the calculation of the rural floor, we refer readers to the FY 2020 IPPS/LTCH PPS final rule (84 FR 42332 through 42336).[42]

Furthermore, there was a comment to the FFY 2022 IPPS proposed rule that stated that the Secretary's Section 401 Hospital Data Exclusion Policy violated the statutory requirement to treat § 412.103 hospitals as located in the rural area of the state and requested that it be rescinded, and that the Secretary include the wages of Section 401 hospitals with an active MGCRB reclassification in calculating the rural wage index of the state in the same manner that geographically rural hospitals with an MGCRB reclassification are treated according to 42 U.S.C. § 1395ww(d)(8)(C)(ii). CMS responded that it had previously addressed these concerns as part of the FY 2017 rulemaking and declined to consider changing it at this time.[43] Specifically, the exchange is as follows, in pertinent part:

> *Comment*: A commenter disagreed with CMS' treatment of hospitals with dual § 412.103 and MGCRB reclassifications. The commenter stated that CMS' policy of considering the hospital's geographic CBSA and the urban CBSA to which the hospital is reclassified under the MGCRB for the wage index calculation **violates** the statutory requirement to treat § 412.103 hospitals as

[41] 42 U.S.C. § 1395hh(a)(2) states "[n]o rule, requirement, or other statement of policy . . . that establishes or changes a substantive legal standard governing . . . the payment of services . . . shall take effect unless it is promulgated by the Secretary by regulation . . . ."
[42] 86 Fed. Reg. 44774 at 45181 (Aug. 13, 2021).
[43] *Id.* at 45181-82.

located in the rural area of the state. The commenter specifically requested that CMS include the wages of § 412.103 hospitals that also have an active MGCRB reclassification in calculating the rural wage of the state if not doing so would reduce the wage index for that area, in the same manner that geographically rural hospitals with a MGCRB reclassification are treated according to § 1886(d)(8)(C)(ii).

Response: We appreciate the commenter's input. We note that CMS includes the wage data of § 412.103 hospitals that do **not** have an MGCRB reclassification in the rural area wage index, consistent with the statutory requirement to treat § 412.103 hospitals as rural. CMS continues to treats § 412.103 hospitals as rural even if such hospitals have an additional MGCRB reclassification by according the hospital the benefits of rural status, such as 340B program and RRC eligibility. However, in developing our policies for how hospitals with dual reclassifications would be treated in wage index calculations following our April 21, 2016 IFC (81 FR 23428 through 23438), CMS discussed the effect of simultaneous § 412.103 and MGCRB reclassifications. We stated that when there is both a § 412.103 reclassification and an MGCRB reclassification, the MGCRB reclassification would control for wage index calculation and payment purposes. We explained that "In these circumstances, we believe it is appropriate to rely on the urban MGCRB reclassification to include the hospital's wage data in the calculation of the urban CBSA wage index. Further, we believe it is appropriate to rely on the urban MGCRB reclassification to ensure that the hospital be paid based on its urban MGCRB wage index. While rural reclassification confers other rural benefits besides the wage index under section 1886(d) of the Act, a hospital that chooses to pursue reclassification under the MGCRB (while also maintaining a rural reclassification under § 412.103) would do so solely for wage index payment purposes." (81 FR 23434). We continue to believe that that policy, developed through rulemaking, is appropriate. Since we did not propose to change our current policy in the FY 2022 IPPS/LTCH PPS proposed rule, we are not making any changes to this policy in this final rule.

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The commenter suggests CMS include the wage data of hospitals with § 412.103 reclassifications in the rural area of the State referenced in *45182 § 1886(d)(8)(C)(ii). The rural area wage index, which according to the commenter should include § 412.103 hospitals, would be compared to a wage index with the effect of

MGCRB reclassifications and Lugar hospital statuses applied, in order to possibly hold the rural area harmless from the effect of MGCRB reclassifications and Lugar hospital statuses. There would be numerous downstream effects of such a policy across IPPS ratesetting that might harm hospitals, contrary to the commenter's intent. For example, using the data associated with this final rule, some states would experience a decline of up to 4.8 percent in their rural wage index if we were to treat hospitals with dual § 412.103 and MGCRB reclassifications no differently than geographically rural hospitals with MGCRB reclassifications, as the commenter suggests. In another example, such a policy would potentially create barriers to MGCRB reclassification for rural and § 412.103 hospitals. If CMS were to treat § 412.103 hospitals in the manner the commenter requests by considering such hospitals' data in the rural area prior to reclassification, then § 412.103 hospitals would have the state's rural area listed as their geographic CBSA in the Three Year Average Hourly Wage (AHW) File used for MGCRB reclassification. As commenters expressed in comments responding to our May 10, 2021 interim final rule with comment period (CMS-1762-IFC) and summarized in section III.K.3. of the preamble of this final rule, assigning the rural CBSA as the geographic CBSA for § 412.103 hospitals in the Three Year AHW File would potentially hamper geographically rural and § 412.103 hospitals' ability to reclassify. Many geographically rural and § 412.103 hospitals would no longer be able to satisfy the wage comparison criteria at § 412.230(d)(1)(iii)(C) (requiring a hospital's average hourly wage to be at least 106 percent of the average hourly wage of all other hospitals in the area in which the hospital is located) if the wages of high-wage § 412.103 hospitals are included in the area in which the hospital is located prior to reclassification. Notably, commenters unanimously requested CMS require § 412.103 hospitals to compare their AHW to the AHW of only hospitals actually located in the rural area, exclusive of hospitals with § 412.103 rural redesignations, for simplicity because hospitals may obtain a § 412.103 reclassification at any time and would change the rural area's AHW and because including § 412.103 reclassifications will change the rural areas AHW.

We did not propose the policy the commenter suggests, and it would constitute a significant change with numerous effects on the IPPS wage index, as enumerated above. We do not think it would be appropriate to adopt such a policy without describing it in a proposed rule and obtaining public comments from all relevant stakeholders. Therefore, in this final rule we are **not** adopting the

> policy the commenter suggested, but will consider further addressing the issue in future rulemaking.[44]

Pursuant to 42 C.F.R. § 405.1867, the Board is bound to apply the statutory and regulatory provisions governing the Medicare program. Consequently, the Board finds that it is bound to by the Uncodified Section 401 Hospital Exclusion Policy set forth in the Interim Final Rule with comment published on April 21, 2016 and the Board does not have the authority to grant the relief sought by the Providers, namely invalidating the Uncodified Section 401 Hospital Exclusion Policy. As a result, the Board finds that EJR is appropriate for the issue for the fiscal year under appeal in these cases.

D. Board's Decision Regarding the EJR Request

The Board finds that:

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

2) Based upon the participants' assertions regarding the Interim Final Rule with Comment published on April 21, 2016, 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 the Uncodified Section 401 Hospital Data Exclusion Policy as published in the April 21, 2016 Interim Final Rule with comment is valid.

Accordingly, the Board finds that the question of the validity of the Uncodified Section 401 Hospital Data Exclusion Policy as published in the April 21, 2016 Interim Final Rule properly falls within the provisions of 42 U.S.C. § 1395oo(f)(1) and hereby grants the Providers' request for EJR for the issue and the subject year. The Providers have 60 days from the receipt of this decision to institute the appropriate action for judicial review. Since this is the only issue under dispute in the three individual and one group case, the Board hereby closes the cases.

Board Members Participating:

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

For the Board:

8/25/2022

X Clayton J. Nix

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

[44] (Bold and underline emphasis added.)

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

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

RE: ***Jurisdictional Challenge and Motion to Dismiss***
Helena Regional Medical Center (Prov. No. 04-0085)
FYE: 12/31/2014
Case No. 17-2247

Dear Mr. Hales,

The Provider Reimbursement Review Board ("Board") has reviewed the Medicare Contractor's motion to dismiss request. The Board's analysis and determination is set forth below.

Pertinent Facts

Helena Regional Medical Center ("Provider") appealed an original Notice of Program Reimbursement ("NPR") dated March 30, 2017 for its fiscal year end December 31, 2014 cost reporting period. On September 15, 2017, the Provider filed an individual appeal request which contained the following issues including those challenged by the MAC below.

- Issue 1: Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific)
- Issue 2: DSH SSI Percentage[1]
- Issue 3: DSH Medicaid Eligible Days
- Issue 4: Uncompensated Care Distribution Pool[2]
- Issue 5: 2 Midnight Census IPPS Payment Reduction[3]

The DSH/SSI - Provider Specific and DSH/Medicaid Eligible Days issues as the only remaining issues on appeal.

The MAC filed a Jurisdictional Challenge on April 10, 2018, regarding Issues 1, 3, and 4.[4] Because the provider thereafter transferred Issue 4 to a group case, this letter only addresses the MAC's challenges to Issues 1 and 3. The Provider has yet to file a response to the MAC's

[1] On June 1, 2018, the Provider transferred this issue to PRRB Case No. 16-2331GC.
[2] On May 31, 2018, the Provider transferred this issue to PRRB Case No. 18-0565GC.
[3] On May 31, 2018, the Provider transferred this issue to PRRB Case No. 18-0682GC.
[4] MAC's Jurisdictional Challenge, at 1.

Jurisdictional Challenge and has not responded to requests for documentation for the Medicaid Eligible Days issue.[5] Per Board Rule 44.4 (July 2015), the Provider "must file a response within 30 days of the Intermediary's jurisdictional challenge" and "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record."

On October 19, 2021, the Board issued a Notice of Hearing and Critical Due Dates setting the hearing for April 29, 22022 and requiring the Provider and Medicare Contractor to file final position papers on January 29, 2022 and February 28, 2022 respectively.

On April 29, 2022, the Board issued a revised Notice of Hearing and Critical Due Dates resettin the hearing for August 29, 2022 and requiring the Provider and Medicare Contractor to file final position papers on May 31, 2022 and June 30, 2022.

On June 16, 2022, the MAC filed a Request for Dismissal, given:

1. The MAC's pending jurisdictional challenge to Issue 1,
2. The Provider's lack of response to three requests to the Provider for Medicaid Eligible Days documentation on November 20, 2017, May 11, 2018, and February 4, 2019, and
3. The Provider's failure to timely file is Final Position Paper ("FPP").[6]

Per Board Rule 44.4.3 (Nov. 1, 2021), the Provider "must file a response within thirty (30) days of the Medicare contractor's jurisdictional challenge unless the Board establishes a shorter deadline via a Scheduling Order" and "[f]ailure to respond will result in the Board making a jurisdictional determination with the information contained in the record.

MAC's Contentions

The MAC's April 10, 2018 Jurisdictional Challenge argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 16-2331GC.[7] The MAC cites prior Board decisions that these issues are considered the same issues.[8]

The MAC also argues that the Board should dismiss the portion of the Provider Specific issue pertaining to realignment because: (1) the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election; (2) the Provider has not exhausted all available remedies prior to requesting a PRRB appeal to resolve the issue; and (3) the Provider should be permitted to raise this issue for the first time before the Board.[9]

---

[5] MAC's Request for Dismissal (alleging that the provider has not responded to requests for documentation for the Medicaid eligible days three times: November 20, 2017; May 11, 2018; February 4, 2019. According to the MAC, the provider has "abandoned" the case.).
[6] *Id.*
[7] Jurisdictional Challenge at 2.
[8] *Id*.
[9] *Id*. at 3 and 5.

Finally, the MAC requested to dismiss the case in a letter dated June 16, 2022. In that letter, the MAC advised they requested documentation from the Provider for the Medicaid eligible days three times: November 20, 2017, May 11, 2018, and February 4, 2019. The Provider has not responded to the requests. Further, the Provider's final position paper was due on May 31, 2022 and remains outstanding.

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

Issue 1: Disproportionate Share Hospital ("DSH") Payment/Supplemental Security Income ("SSI") Percentage (Provider Specific)

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was transferred to 16-2331GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[10] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[11] The Provider argues that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[12]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 16-2331GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage,

[10] Issue Statement at 1.
[11] *Id.*
[12] *Id.*

the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 16-2331GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[13], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, is pursuing that issue as part of the group under Case 16-2331GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[14] Provider is misplaced in referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 16-2331GC.

To this end, the Board would review the Provider's response to the Jurisdictional Challenge to see if it further clarified Issue 1. However, the Provider never filed its response in compliance with Board Rule 44.4 (July 2015) and, to this date has not responded. Accordingly, the Board must make its determination on the record before it and, based on this record, there is no basis upon which to distinguish the Systemic Errors issue from the Provider Specific issue in the existing record. The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[15] And the Provider failed to file its FPP and to give any update on those efforts in direct violation of Board Rule 25.2.2:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

Accordingly, the Board finds that the Provider Specific and the Systemic Errors issues are the same issue. Because the issue is duplicative, and duplicative issues appealed from the same final

[13] PRRB Rules v. 1.3 (July 2015).
[14] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[15] (Emphasis added.)

determination are prohibited by Board Rule 4.5 (2015), the Board dismisses this component of the DSH/SSI (Provider Specific) issue.

The second aspect of the DSH SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. As such, the Board dismisses the DSH Payment/SSI Percentage – Provider Specific issue from the instant appeal.

Issue 3: DSH Medicaid Eligible Days

The Board finds that the Provider has abandoned the Medicaid Eligible Days issue, and therefore dismisses the issue from this appeal. With regard to the filing of an individual appeal, Board Rule 7 (Support for Appealed Final Determination, Issue-Related Information and Claim of Dissatisfaction) states:

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

Similarly, with regard to position papers,[16] Board Rule 25.2.1 requires that "the parties must exchange all available documentation as exhibits to fully support your position."

Board Rule 25.2.2 provides the following instruction on the content of position papers:

> If documents necessary to support your position are still unavailable, then provide the following information in the position papers:
>
> 1. Identify the missing documents;
>
> 2. Explain why the documents remain unavailable;
>
> 3. State the efforts made to obtain the documents; and

[16] The minimum requirements for Final Position Paper narratives and exhibits is the same as those for Preliminary Position Papers. *See* PRRB Rule 27.2.

4. Explain when the documents will be available.

Once the documents become available, promptly forward them to the Board and the opposing party.

When determining a hospital's Disproportionate Share Percentage (and the Medicaid Eligible Days which affect the percentage), 42 C.F.R. § 412.106(b)(iii) places the burden of production on the provider, stating:

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

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

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

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

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

The Board recognizes that Board Alert 19 suspended Board-set deadlines. However, the Provider has been complete nonresponsive in this case despite multiple contacts from the Board both prior to and after Alert 19. In this regard, the Board notes that the Medicare Contractor has clearly requested that the Provider submit documentation on the Medicaid eligible days issue, on November 20, 2017, May 11, 2018, and February 4, 2019 and the Provider has been nonresponsive to those requests. Similarly, the Provider failed to respond to the Jurisdictional Challenge filed on April 10, 2018. Further, the Provider failed to file its Final Position Paper and supporting documentation and failed to respond to the Medicare Contractor's Motion to Dismiss, notwithstanding an extension being given. Indeed, this case has been pending almost 5 years (filed on September 15, 2017) and the Provider has yet to share with the Board or the opposing part a listing of the days that are in dispute notwithstanding the Medicare Contractors multiple

requests for this information and its obligation to enter this information into the record as part of the position paper process (both preliminary and final position papers).[17] In this same vein, the Board notes that the last action in this case taken by the Provider was more than 4 years ago on June 1, 2018 when it filed the cover page of its preliminary position paper and transferred Issue 2 to Case No. 16-2331GC. Based on the clear non-responsiveness of the Provider, the Board must find that it has abandoned its appeal of this issue, and therefore dismisses the Medicaid eligible days issue from the appeal.

As the Board has dismissed the last two remaining issues in the appeal, the Board closes Case No. 17-2247 and removes it from the Board's docket. Review of this determination may be available under the provisions of 42 U.S.C. § 1395oo(f) and 42 C.F.R. §§ 405.1875 and 405.1877.

Board Members Participating:

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

For the Board:

8/26/2022

X Clayton J. Nix

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

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

[17] *See* 42 C.F.R. § 405.1853(b)(3) ("In the absence of a Board order or general instructions to the contrary, any supporting exhibits regarding Board jurisdiction must accompany the position paper"); Notice of Hearings giving instructions on position papers noting that it "must also include any exhibits the Provider will use to support its position"; Board Rules 27, 27 (Nov. 2021); Board Rule 25.2 ("With the position papers, the parties must exchange all available documentation as exhibits to fully support your position.").

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

Lilian Gong
Gong Nashed Pascoe, Inc.
2504 Siwanoy Drive
Alhambra, CA 91803-4643

Lorraine Frewert, Appeals Coordinator
Noridian Healthcare Solutions c/o
Cahaba Safeguard Administrators (J-E)
P.O. Box 6782
Fargo, ND 58108-6782

RE: GNP/Adventist Health 2007 DSH Medicaid Ratio-Medicare Part C Days CIRP Group
PRRB Case No. 15-0894GC

Dear Ms. Gong and Ms. Frewert:

The above-referenced group appeal includes a challenge to the inclusion of Medicare Part C days in the Medicare fraction of the disproportionate share ("DSH") percentage and/or the exclusion of Medicare Part C days for patients who are dually eligible for Medicaid from the Medicaid fraction of the DSH percentage, for patient discharges *before* October 1, 2013. This issue is governed by Centers for Medicare & Medicaid Services ("CMS") Ruling CMS-1739-R and, under the terms of this Ruling, the Provider Reimbursement Review Board (the "Board") must review the jurisdictional documentation to determine if the group issue should be remanded to the Medicare Contractor for calculation of the DSH payment adjustment in accordance with the forthcoming final rule CMS will issue "to govern the treatment of [Medicare Part C] patient days with discharge dates before October 1, 2013." *See also* 58 Fed. Reg. 47723 (Aug. 6, 2020).

Based on this Ruling, the Board has reviewed the jurisdictional documentation in Case No. 15-0894GC. The background of the case and the Board's determination are set forth below.

Background:

On January 5, 2015, Gong Nashed Pascoe, Inc. ("Gong Nashed") filed the "Adventist Health 2007 Medicaid Ratio – Medicare Part C Days CIRP Group" under Case No. 15-0894GC. The group, which has not yet been designated to be complete, currently has 2 participants, both of which were transferred from individual appeals:

Provider Name/No.	**FYE**	**Transfer From**	**Transfer Date**	**Individual Case Closure Date**
White Memorial Medical Center (05-0103)	12/31/2007	13-2359	1/20/2015	4/24/2018
San Joaquin Community Hospital (05-0455)	12/31/2007	13-2405	8/31/2015	7/8/2016

Two years earlier, on February 15, 2013, CampbellWilson, LLP filed an SSI Fraction Part C Days group under Case No. 13-0764GC. On April 21, 2021, the Board remanded the "CampbellWilson-Adventist 2007 SSI Part C Days CIRP Group," to the Medicare Contractor pursuant to CMS Ruling 1739R. At the

time it was remanded, Case No. 13-0764GC included nine participants, including the two participants currently in Case No. 15-0894GC.[1]

Board Determination:

Having reviewed the pertinent facts in each group, the Board finds that the 1739-R remand for the SSI Fraction Part C Days group issued under Case No. 13-0764GC, which the Board granted on April 21, 2021, clearly encompassed the ***complete*** Part C DSH issue, *i.e.*, both the Medicare and Medicaid fraction for the providers in Case No. 15-0894GC. Per the holdings in *Allina Health Servs. v. Sebelius* (746 F.3d 1102, 1108 (D.C. Cir. 2014)) ("*Allina*"), Part C days ***must*** be included in either the SSI fraction or Medicaid fraction. Thus, the disposition of the SSI Fraction Medicare Part C Days issue dictates the disposition of the Medicaid Fraction Medicare Part C Days issue, as *Allina* indicates Part C days must be counted in one fraction or the other.

As such, the Board finds that the Medicaid Fraction Medicare Part C Days CIRP group, currently under appeal in Case No. 15-0894GC, is duplicative of the issue that was previously handled through the remand of the DSH SSI Fraction Part C Days Group under Case No. 13-0764GC. Therefore, the Board hereby dismisses the GNP/Adventist Health 2007 DSH Medicaid Ratio Part C Days CIRP group, Case No. 15-0894GC, and removes it from the 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:

8/29/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Esq., CPA, Federal Specialized Services
Manie Campbell, Campbell Wilson, LLP

[1] White Memorial Medical Center was directly added to Case No. 13-0764GC on 8/14/2013 and San Joaquin Community Hospital was directly added to the group on 8/19/2013.

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

Via Electronic Delivery

James Ravindran
Quality Reimbursement Services, Inc.
150 N. Santa Anita Avenue, Suite 570A
Arcadia, CA 91006

RE: **Jurisdictional Challenge**
Sycamore Shoals Hospital (Prov. No. 44-0018)
FYE: 06/30/2014
PRRB Case: 17-1302

Dear Mr. Ravindran,

The Provider Reimbursement Review Board ("Board") has reviewed the documents in the above referenced appeal and dismisses the Disproportionate Share Hospital ("DSH") Payment / Supplemental Security Income ("SSI") Percentage - Provider Specific issue for the reasons set forth below.

Pertinent Facts

On October 4, 2016, the Provider was issued a final Notice of Program Reimbursement ("NPR") for fiscal year end June 30, 2014.

On March 31, 2017, the Board received the Provider's individual appeal request. The initial Individual Appeal Request contained eight (8) issues:

1. DSH Payment/SSI Percentage – Provider Specific
2. DSH/SSI Percentage – Systemic Errors[1]
3. DSH Payment - SSI Fraction/Medicare Managed Care Part C Days[2]
4. DSH Payment - SSI Fraction/Dual Eligible Days[3]
5. DSH Payment – Medicaid Eligible Days[4]
6. DSH Payment – Medicaid Fraction/Medicare Managed Care Part C Days[5]
7. DSH Payment – Medicaid Fraction/Dual Eligible Days[6]
8. Outlier Payments – Fixed Loss Threshold[7]

The only remaining issue is the DSH Payment/SSI Percentage – Provider Specific issue.

[1] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0199GC.
[2] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0200GC.
[3] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0205GC.
[4] Issue withdrawn by the Provider on November 29, 2017.
[5] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0204GC.
[6] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0206GC.
[7] On November 7, 2017, this issue was transferred to PRRB Case No. 18-0198GC.

In their Individual Appeal Request, Provider summarizes its DSH/SSI – Provider Specific issue as follows:

> The Provider contends that its SSI percentage published by [CMS] was incorrectly computed because CMS failed to include all patients that were entitled to SSI benefits in their calculation.
>
> . . .
>
> The Provider is seeking SSI data from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage. The Provider also hereby preserves its right to request under separate cover that CMS recalculate the SSI percentage based upon the Provider's cost reporting period.[8]

Provider described its DSH/SSI – Systemic Errors issue, which has been transferred to a group appeal, as whether the Medicare/SSI Fraction used to calculate their DSH payment accurately and correctly counted the number of patient days to be included therein. More specifically, Provider lists the following reasons for challenging its SSI percentage:

1. Availability of MEDPAR and SSA records,
2. Paid days vs Eligible days,
3. Not in agreement with provider's records,
4. Fundamentals problems in the SSI percentage calculation,
5. Covered days vs Total days, and
6. Failure to adhere to required notice and comment rulemaking procedures.[9]

MAC's Jurisdictional Challenge

The Board received a Jurisdictional Challenge filed on behalf of the Medicare Administrative Contractor ("MAC") on May 11, 2018, which argued that the Board lacks jurisdiction over the DSH/SSI Percentage - Provider Specific issue because it is duplicative of the issue which was transferred to case 18-0199GC.[10] The MAC cites prior Board decisions that these issues are considered the same issues.[11] The MAC goes on to cite language in a prior Board decision:

> The SSI data is the underlying issue for both SSI% "Provider Specific" and SSI % "Systemic Errors." The Board finds that SSI% is one issue for appeal purposes. Specifically, the SSI% "Provider Specific" issue that was briefed is a subset of the SSI% "Systemic Errors" issue that was transferred. Therefore, the Board concludes that this issue was previously transferred to a group appeal…[12]

---

[8] Issue Statement at 1. (March 31, 2017).
[9] *Id.* at 2.
[10] Jurisdictional Challenge at 3. (Apr. 17, 2018).
[11] *Id*.
[12] *Id*. at 4. Quoting *Cox Health* (PRRB Case 10-0181, Jan. 22, 2015) at 2-3.

The MAC also cites Board Rule 4.5 (v. 1.3, July 1, 2015), arguing the Provider is appealing an issue from a final determination in more than one appeal.[13]

The MAC also argues that the Board should dismiss the portion of the Provider Specific issue pertaining to realignment because: (1) the decision to realign a hospital's SSI percentage with its fiscal year end is a hospital election; and (2) appealing this issue is premature since the Provider did not request an SSI realignment and, as such, there was no final determination to appeal.[14]

Provider's Jurisdictional Response

The Board received a Jurisdictional Response filed on behalf of the Provider on May 11, 2018, which argued that the Board has jurisdiction over the DSH/SSI issues which includes both the "provider specific" and realignment sub-issues.[15] The Provider stated that it is "not only addressing a realignment of the SSI percentage, but also addressing the various errors of omission and commission that do not fit into the 'systemic errors' category."[16] They go on to argue that the two appeal issues "represent different aspects/components of the SSI issue."[17]

Board Decision

Pursuant to 42 U.S.C. § 1395oo(a) and 42 C.F.R. §§ 405.1835 – 405.1840 (2018), a provider has a right to a hearing before the Board with respect to costs claimed on a timely filed cost report if it is dissatisfied with the final determination of the Medicare contractor, the amount in controversy is $10,000 or more (or $50,000 for a group), and the request for a hearing is filed within 180 days of the date of receipt of the final determination.

The Board finds that it does not have jurisdiction over the DSH/SSI Percentage - Provider Specific issue. The jurisdictional analysis for Issue No. 1 has two relevant aspects to consider: 1) the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage, and 2) the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period.

The first aspect of Issue No. 1—the Provider disagreeing with how the Medicare Contractor computed the SSI percentage that would be used to determine the DSH percentage—is duplicative of the DSH SSI Percentage - Systemic Error issue that was transferred to 18-0199GC.

The DSH/SSI Percentage - Provider Specific issue in the present appeal concerns "whether the Medicare Administrative Contractor used the correct Supplemental Security Income percentage in the Disproportionate Share Hospital calculation."[18] The Provider's legal basis for its DSH/SSI - Provider Specific issue asserts that the Medicare Contractor "did not determine Medicare DSH reimbursement in accordance with the Statutory instructions at 42 U.S.C. § 1395ww(d)(5)(F)(i)."[19] The Provider argues

[13] *Id*. at 4.
[14] *Id*.
[15] Provider's Jurisdictional Response at 1 (May 11, 2018).
[16] *Id*. at 2.
[17] *Id.* at 1.
[18] Issue Statement at 1.
[19] *Id.*

that "its SSI percentage published by the Centers for Medicare and Medicaid Services was incorrectly computed . . . ." and it ". . . specifically disagrees with the [Medicare Contractor]'s calculation of the computation of the DSH percentage set forth at 42 C.F.R. § 412.106(b)(2)(i) of the Secretary's Regulations."[20]

The Provider's DSH SSI Percentage - Systemic Errors issue in group Case No. 18-0199GC also alleges that the Medicare Contractor and CMS improperly determined the DSH SSI Percentage, the DSH SSI Percentage is improper due to a number of factors, and the DSH payment determination was not consistent with 42 U.S.C. § 1395ww(d)(5)(F) and 42 C.F.R. § 412.106. Thus, the Board finds the DSH SSI Percentage (Provider Specific) issue in this appeal is duplicative of the DSH SSI Percentage - Systemic Errors issue in Case No. 18-0199GC. Because the issue is duplicative, and duplicative issues appealed from the same final determination are prohibited by PRRB Rule 4.5[21], the Board dismisses this aspect of the DSH/SSI Percentage - Provider Specific issue.

In making this finding, the Board further notes that CMS regulation interpretation for the SSI percentage is clearly not "specific" to only this provider. Rather, it applies to all SSI calculations and, to that end, the Provider is pursuing that issue as part of the group under Case 18-0199GC. Further, any alleged "systemic" issues may not uniformly impact all providers but, as was the case in *Baystate*, may impact the SSI percentage for each provider differently.[22] Provider's reliance on referring to Issue 1 as "Provider Specific" and keeping it in an individual appeal is misplaced. In this respect, the Provider has failed to sufficiently explain (or give any examples or provide evidence) how the alleged "provider specific" errors can be distinguished from the alleged "systemic" issue rather than being subsumed into the "systemic" issue appealed in Case No. 18-0199GC.

To this end, the Board staff would also review the Provider FPP to see if it further clarified Issue 1. However, the Provider has not filed its FPP and there is no basis upon which to distinguish the Systemic Errors issue from the Provider Specific issue in the existing record**.** The Provider stated in its appeal that it was "seeking *SSI data* from CMS in order to reconcile its records with CMS data and identify records that CMS failed to include in their determination of the SSI percentage."[23] The Provider fails to give any update on those efforts in direct violation of Board Rule 25.2.2:

> If documents necessary to support your position are still unavailable, identify the missing documents, explain why the documents remain unavailable, state the efforts made to obtain the documents, and explain when the documents will be available. Once the documents become available, promptly forward them to the Board and the opposing party.

Accordingly, the Board finds that the Provider Specific and the Systemic Errors issues are the same issue.

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[20] *Id.*
[21] PRRB Rules v. 1.3 (July 2015).
[22] The types of systemic errors documented in the *Baystate* did not uniformly impact the SSI calculation for all providers but that does not may the errors any less systemic. *See Baystate Medical Ctr. v. Mutual of Omaha Ins. Co.*, PRRB Dec. No. 2006-D20 (Mar. 17, 2006). *See also Baystate Med. Ctr. v. Leavitt*, 545 F. Supp. 2d 20 (D.D.C. 2008).
[23] (Emphasis added.)

The second aspect of the DSH SSI Percentage - Provider Specific issue—the Provider preserving its right to request realignment of the SSI percentage from the federal fiscal year to its cost reporting period—is dismissed by the Board.

The Board finds that, under 42 C.F.R. § 412.106(b)(3), for determining a Provider's DSH percentage, "[i]f a hospital prefers that CMS use its cost reporting data instead of the Federal fiscal year, it must furnish to CMS, through its intermediary, a written request . . ." Without this written request, the Medicare Contractor cannot issue a final determination from which the Provider can be dissatisfied with for appealing purposes. There is nothing in the record to indicate the Medicare Contractor has made a final determination regarding DSH SSI Percentage realignment. Therefore, the Board finds that it lacks jurisdiction in this aspect of the appeal. As such, the Board dismisses the DSH Payment/SSI Percentage – Provider Specific issue from the instant appeal.

As this was the only remaining issues in the appeal, the Board closes the case and removes it from the Board's docket.

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

Board Members Participating:

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

For the Board:

8/29/2022

X Kevin D. Smith, CPA

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

cc: Wilson C. Leong, Federal Specialized Services
Cecile Huggins, Palmetto GBA (J-J)